

<i>SERFF Tracking Number:</i>	<i>KCLF-126100878</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Kansas City Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42268</i>
<i>Company Tracking Number:</i>	<i>PJ139</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.005 Combined Short Term and Long Term</i>
<i>Product Name:</i>	<i>Group Disability Insurance</i>		
<i>Project Name/Number:</i>	<i>/PJ139</i>		

## Filing at a Glance

Company: Kansas City Life Insurance Company

Product Name: Group Disability Insurance	SERFF Tr Num: KCLF-126100878	State: ArkansasLH
TOI: H11G Group Health - Disability Income	SERFF Status: Closed	State Tr Num: 42268
Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: PJ139		State Status: Approved-Closed
Long Term		
Filing Type: Form	Co Status: Pending	Reviewer(s): Rosalind Minor
	Author: Dietter Foster-Redmond	Disposition Date: 05/06/2009
	Date Submitted: 05/04/2009	Disposition Status: Approved-Closed
		Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number: PJ139	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 05/06/2009	Explanation for Other Group Market Type:
	State Status Changed: 05/06/2009
Deemer Date:	Corresponding Filing Tracking Number: PJ139

Filing Description:

Purpose

No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. This is a new filing and the forms present a program of group disability income insurance. They will not replace any other form

The forms are in final printed form subject to changes in font style, margins, page numbers, order of forms, ink and

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paper stock. Pages are numbered before any options are selected and, therefore, the page numbers will roll accordingly. Printing standards will never be less than those required by law. Once approved, the Company reserves the right to use the forms in their approved format in a variety of media, including the internet, with the understanding that there may be slight accommodations made for electronic viewing.

#### Marketing Strategy:

This group disability income product will be marketed primarily to employer groups, both small and large. However, we are also requesting approval for issue to association, trust and labor union groups.

#### Variability of Forms

The variable material is set off by brackets to be variable so that it may be added to, deleted from or changed. Both the booklet-certificate and the Policy of Incorporation are accompanied by Statements of Variable Language to explain the intended range of variability.

## Company and Contact

#### Filing Contact Information

Dietter Foster-Redmond, Compliance Analyst	dfoster-redmond@kclife.com
P O Box 219139	(800) 821-5529 [Phone]
Kansas City, MO 64121-9139	(816) 753-3018[FAX]

#### Filing Company Information

Kansas City Life Insurance Company	CoCode: 65129	State of Domicile: Missouri
P O Box 219139	Group Code: 588	Company Type: Life
Kansas City, MO 64121-9139	Group Name:	State ID Number:
(800) 821-5529 ext. [Phone]	FEIN Number: 44-0308260	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	\$50 per policy

<i>SERFF Tracking Number:</i>	<i>KCLF-126100878</i>	<i>State:</i>	<i>Arkansas</i>
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<b>Per Company:</b>	<b>No</b>		

*SERFF Tracking Number:*      *KCLF-126100878*                      *State:*                      *Arkansas*  
*Filing Company:*              *Kansas City Life Insurance Company*              *State Tracking Number:*              *42268*  
*Company Tracking Number:*      *PJ139*  
*TOI:*                      *H11G Group Health - Disability Income*              *Sub-TOI:*                      *H11G.005 Combined Short Term and Long Term*  
*Product Name:*              *Group Disability Insurance*  
*Project Name/Number:*              */PJ139*

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kansas City Life Insurance Company	\$100.00	05/04/2009	27620067

SERFF Tracking Number:	KCLF-126100878	State:	Arkansas
Filing Company:	Kansas City Life Insurance Company	State Tracking Number:	42268
Company Tracking Number:	PJ139		
TOI:	H11G Group Health - Disability Income	Sub-TOI:	H11G.005 Combined Short Term and Long Term
Product Name:	Group Disability Insurance		
Project Name/Number:	/PJ139		

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/06/2009	05/06/2009

<i>SERFF Tracking Number:</i>	<i>KCLF-126100878</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>Group Disability Insurance</i>		
<i>Project Name/Number:</i>	<i>/PJ139</i>		

## Disposition

Disposition Date: 05/06/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: KCLF-126100878 State: Arkansas

Filing Company: Kansas City Life Insurance Company State Tracking Number: 42268

Company Tracking Number: PJ139

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: Group Disability Insurance

Project Name/Number: /PJ139

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	statement of variability	Approved-Closed	Yes
Supporting Document	Actuarial Support	Approved-Closed	Yes
Form	Group Short Term Disability Income Insurance	Approved-Closed	Yes
Form	Group Short Term Disability Income Insurance	Approved-Closed	Yes
Form	Group Long Term Disability Income Insurance	Approved-Closed	Yes
Form	Group Long Term Disability Income Insurance	Approved-Closed	Yes

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TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: Group Disability Insurance  
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## Form Schedule

**Lead Form Number:** PJ139

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	PJ139	Policy/Contract/Group Short Term Disability Income Insurance Certificate		Initial		0	STD PJ139-basic.pdf
Approved-Closed	CJ139	Certificate	Group Short Term Disability Income Insurance	Initial		0	STD CJ139-basic.pdf
Approved-Closed	PJ140	Policy/Contract/Group Long Term Disability Income Insurance Certificate		Initial		0	LTD PJ140-basic.pdf
Approved-Closed	CJ140	Certificate	Group Long Term Disability Income Insurance	Initial		0	LTD CJ140-basic.pdf



**KANSAS CITY LIFE  
INSURANCE COMPANY**

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GROUP SHORT TERM DISABILITY INCOME INSURANCE POLICY  
NON-PARTICIPATING

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POLICYHOLDER:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICY ANNIVERSARY DATE: [A date established and agreed to by the Policyholder and Us]

GOVERNING JURISDICTION:

Kansas City Life Insurance Company (referred to as Kansas City Life) will provide benefits under this policy. Kansas City Life makes this promise subject to all of this policy's provisions.

The Policyholder should read this policy carefully and contact Kansas City Life promptly with any questions. This policy is delivered in and is governed by the Laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This entire policy consists of:

1. all policy provisions and any amendments and/or attachments issued;
2. the Certificate of Coverage; and
3. the Policyholder's signed application[.]; and
4. the Employers' signed participation agreements; and]
5. the Insured Persons' signed Enrollment Forms.]

This policy may be changed in whole or in part. Only an officer [or registrar] of Kansas City Life can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, PO Box 219425, Kansas City, MO 64121-9425.

Secretary

President, CEO and Chairman

**KANSAS CITY LIFE INSURANCE COMPANY**  
3520 Broadway, Kansas City, MO 64111  
816-753-7000



**POLICY TABLE OF CONTENTS**

**PAGE NUMBER**

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## **POLICYHOLDER PROVISIONS**

### **INCONTESTABILITY**

The validity of the policy shall not be contested after the policy has been in effect for two years except in situations when:

1. premium has not been paid; or
2. for fraudulent misrepresentations.

**[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDED][PARTICIPATING EMPLOYERS]:**

**NAME LOCATION (CITY AND STATE)**

[None]

[XYZ Company] [City, State]

### **ELIGIBLE CLASS(ES):**

[All Employees] in Active Employment in the United States with the Employer.

Employee must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

[All persons who meet the membership eligibility criteria of the Policyholder.]

[All persons in Active Employment [in the United States] with the Employer.]

[Persons who are not legal residents or citizens of the United States are not eligible for coverage.]

### **MINIMUM HOURS REQUIREMENT:**

[30 hours per week]

### **WAITING PERIOD:**

For persons in an eligible class on or before the policy effective date: [None]

[A continuous period of [1-365 days] of Active Employment.]

[End of the month in which the Employee completes a continuous period of [1-365 days] of Active Employment.]

For persons entering an eligible class after the policy effective date:

[A continuous period of [1-365 days] of Active Employment.]

[End of the month in which the Employee [completes a continuous period of [1-365 days]][begin] of Active Employment.]

### **COST OF INSURANCE**

The initial premium for the policy is based on the initial rate(s) shown below.

[[Monthly] [Quarterly] rate of [x%] of [Weekly Covered Payroll] [Weekly Benefit]]

[[Monthly] [Quarterly] rate of [\$xx.xx] [per \$10 of [Weekly Benefit] [Weekly Covered Payroll]]

[[Monthly] [Quarterly] cost of [\$xxxx.xx] [per Insured Person]]

[Age]	[Monthly][Quarterly] rate per \$10 of [Weekly Benefit] [Weekly Covered Payroll]
Less than age 25	xx.xx
25-29	xx.xx
30-34	xx.xx
35-39	xx.xx
40-44	xx.xx
45-49	xx.xx
50-54	xx.xx
55-59	xx.xx
60-64	xx.xx

65-69  
70 and over

xx.xx  
xx.xx]

[**WEEKLY COVERED PAYROLL** means the total amount of Weekly Earnings for which Employees are Insured under the policy.]

### **INITIAL RATE GUARANTEE AND RATE CHANGES**

A change in premium rates will not take effect before [MM/DD/YYYY] (Rate Guarantee Period).

However, We may change premium rates at any time for reasons which affect the risk assumed, including but not limited to those reasons shown below:

1. a change occurs in this policy design;
2. the number of Insureds changes by [10%-25%] or more; or
3. a new Law or a change in any existing Law is enacted which applies to this policy.

We will notify the Policyholder in writing at least [30-60] days before a premium rate is changed. A change may take effect on an earlier date when both the Policyholder and We agree.

### **WHEN PREMIUM IS DUE**

Premium Due Dates: [MM/DD/YYYY] and the [first day] of each [calendar month] thereafter.

The Policyholder must send all premiums to Us on or before their respective due date. The premium must be paid in United States dollars.

### **PREMIUM INCREASES OR DECREASES**

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

Premium charges for new Insured Persons or for increases in insurance amounts will begin on the premium due date which coincides with or next follows the date of the addition or the change. Premium charges for terminated persons will end, and decreases for insurance amounts will begin, on the premium due date which coincides with or next follows the termination or the change in amount. This method of charging premium will neither commence any insurance after the date it would otherwise begin nor extend any insurance coverage beyond the date it would otherwise terminate pursuant to the applicable effective date or termination provisions of the policy.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

We will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

(Standard)

### **[INFORMATION REQUIRED FROM THE POLICYHOLDER**

The Policyholder must provide Us with the following on a regular basis:

1. information about persons:
  - a. who are eligible to become insured; and
  - [b.] [who Enroll for coverage [and their initial amount of coverage];]
  - c. whose amounts of coverage change; and
  - d. whose coverage ends;
2. occupational and salary information and any other information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in Our opinion, on this policy will be available for review by Us at any reasonable time as determined by Us.]

(Alternative)

**[INFORMATION REQUIRED FROM THE POLICYHOLDER**

The Policyholder must provide Us with detailed information about persons who are eligible to become insured under this policy, information about Insured Persons, and any other information that may be reasonably required.

Policyholder [and Employer] records that have a bearing, in Our opinion, on this policy will be available for review by Us at any reasonable time as determined by Us.]

**INFORMATION PROVIDED BY US**

We will furnish the Policyholder with a Certificate of Coverage which outlines the benefits under this policy. The [Policyholder][Employer] will distribute a Certificate of Coverage to each Insured Person.

(Standard)

**[AMENDING OR CANCELING THE POLICY**

This policy can be canceled:

1. by Us; or
2. by the Policyholder.

We may amend or cancel this policy if:

1. [there is less than [5%-100%] participation of those eligible persons who pay all or part of their premium for the policy;]  
[there is less than 100% participation of those eligible persons working for a Policyholder with 3 to 5 eligible persons];
2. the participation requirement is not met for a Policyholder with 6 to 9 eligible persons who pay a part of their premium for the policy:

<u>Eligible Persons</u>	<u>Participation Requirement</u>
6	5 enrolled
7	6 enrolled
8	6 enrolled
9	7 enrolled]

3. there is less than 100% participation of those eligible persons for a Policyholder paid plan;
4. the Policyholder does not promptly provide Us with information that is reasonably required;
5. the Policyholder fails to perform any of its obligations that relate to this policy;
6. fewer than [2-10] persons are insured under the policy;
7. the premium is not paid in accordance with the provisions of this policy;
8. the Policyholder does not promptly report to Us the names of any persons who are added or deleted from the eligible class(es);
9. We determine that there is a significant change, in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its persons; or
10. the Policyholder fails to pay any portion of the premium within the [31-60] day Grace Period.

We reserve the right to review and terminate all class(es) covered under the policy if any class(es) cease(s) to be covered.

If We amend or cancel this policy for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least [30-60] days prior to the amendment date or cancellation date. The Policyholder may cancel this policy if the amendments are unacceptable.

If any portion of the premium is not paid during the Grace Period, the policy will terminate automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period. The Policyholder must pay Us all premium due for the full period the policy is in force.

The Policyholder may cancel this policy by written notice delivered to Us at least [30-60] days prior to the cancellation date. When both the Policyholder and We agree, this policy can be canceled on an earlier date. If the Policyholder or We cancel this policy, coverage will end at 12:00 midnight Standard Time at the Policyholder's address on the last day of coverage.

If this policy is canceled, the cancellation will not affect a Payable Claim.]

(Alternative)

**[CANCELING THE POLICY [OR AN EMPLOYER'S PLAN OF COVERAGE UNDER THE POLICY]**

This policy [or an Employer's plan of coverage under the policy] can be canceled:

1. by Us; or
2. by the Policyholder.

We may cancel this policy [or an Employer's plan of coverage under the policy] on any premium due date after the first policy Anniversary Date by giving at least [30-60] days advance written notice of termination to the Policyholder.

If fewer than [10-500] persons are insured under the policy [or an Employer's plan of coverage under the policy], We may cancel this policy [or an Employer's plan of coverage under the policy] at any time by giving at least [30-60] days advance written notice of termination to the Policyholder.

We reserve the right to review and terminate all class(es) covered under the policy if any class(es) cease(s) to be covered.

If any portion of the premium is not paid during the [31-60] day Grace Period, the policy will terminate automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period. The Policyholder must pay Us all premium due for the full period the policy is in force.

The Policyholder may cancel this policy [or an Employer's plan of coverage under the policy] by written notice delivered to Us at least [30-60] days prior to the cancellation date. When both the Policyholder and We agree, this policy [or an Employer's plan of coverage under the policy] can be canceled on an earlier date. If the Policyholder or We cancel this policy [or an Employer's plan of coverage under the policy], coverage will end at 12:00 midnight Standard Time at the Policyholder's address on the last day of coverage.

If this policy [or an Employer's plan of coverage under the policy] is canceled, the cancellation will not affect a Payable Claim.]

(Alternative)

**[AMENDING OR CANCELING THE POLICY [OR AN EMPLOYER'S PLAN OF COVERAGE UNDER THE POLICY]**

This policy [or an Employer's plan of coverage under the policy] can be canceled:

1. by Us; or
2. by the Policyholder.

We may amend or cancel this policy [or an Employer's plan of coverage under the policy] if:

1. the Policyholder [or Employer] does not promptly provide Us with information that is reasonably required;
2. the Policyholder fails to perform any of its obligations that relate to this policy;
3. fewer than [10-500] persons are insured under the policy;
4. the premium is not paid in accordance with the provisions of this policy;
5. We determine that there is a significant change, in the size, occupation or age of the eligible class(es); or
6. the Policyholder fails to pay any portion of the premium within the [31-60] day Grace Period.

We reserve the right to review and terminate all class (es) covered under the policy if any class(es) cease(s) to be covered.

If We amend or cancel this policy [or an Employer's plan of coverage under the policy] for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least [30-60] days prior to the amendment date or cancellation date. The Policyholder may cancel this policy [or an Employer's plan of coverage under the policy] if the amendments are unacceptable.

If any portion of the premium is not paid during the Grace Period, the policy will terminate automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period. The Policyholder must pay Us all premium due for the full period the policy is in force.

The Policyholder may cancel this policy [or an Employer's plan of coverage under the policy] by providing written notice to Us at least [30-60] days prior to the cancellation date. When both the Policyholder and We agree, this policy [or an Employer's plan of coverage under the policy] can be canceled on an earlier date. If the Policyholder or We cancel this policy [or an Employer's plan of coverage under the policy], coverage will end at 12:00 midnight Standard Time at the Policyholder's address on the last day of coverage.

If this policy [or an Employer's plan of coverage under the policy] is canceled, the cancellation will not affect a Payable Claim.]

#### **[ASSIGNMENT**

The Policyholder may assign the policy, however the Policyholder is required to advise all certificateholders of any assignment in writing, via certified mail. None of the Insured Persons' rights will be affected. Such assignment will not affect Us until We receive written notice at Our home office and give Our written approval.]

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# GROUP INSURANCE BENEFITS

**Group Name**

**Short Term Disability Insurance**



**KANSAS CITY LIFE  
INSURANCE COMPANY**

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**KANSAS CITY LIFE  
INSURANCE COMPANY**

**GROUP SHORT TERM DISABILITY INCOME INSURANCE**

**CERTIFICATE OF COVERAGE**

POLICYHOLDER:

POLICY NUMBER:

POLICYHOLDER EFFECTIVE DATE:

GOVERNING JURISDICTION:

[EMPLOYER:]

[EMPLOYER PLAN EFFECTIVE DATE:]

[EMPLOYER IDENTIFICATION NUMBER:]

Kansas City Life Insurance Company (referred to as Kansas City Life) welcomes You as a certificateholder.

**This is Your Certificate of Coverage as long as You are eligible for coverage and You become Insured. You will want to read it carefully and keep it in a safe place.**

We have written Your Certificate of Coverage in understandable terms. However, a few terms and provisions are written as required by insurance Law. If You have any questions about any of the terms and provisions, please consult Our claims paying office. We will assist You in any way to help You understand Your benefits.

If the terms and provisions of the Certificate of Coverage (issued to You) are different from the policy (issued to the Policyholder), the policy will govern. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the Laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, We have discretionary authority within the reasonable limits established by the law to determine Your eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. Standard Time at the Policyholder's address and end at 12:00 midnight Standard Time at the Policyholder's address.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, PO Box 219425, Kansas City, MO 64121-9425.

Secretary

President, CEO and Chairman

**The policy [covers][does not cover] disabilities due to an Occupational Sickness or Injury.**

**The policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.**

**CERTIFICATE OF COVERAGE**  
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## **SCHEDULE OF BENEFITS**

### **SHORT TERM DISABILITY**

The Short Term Disability policy provides financial protection for You by paying a portion of Your income while You are disabled. The amount You receive is based on the amount You earned before Your disability began, subject to all policy provisions.

**NAME OF EMPLOYER:**

**POLICY NUMBER:** [xxxxx]

**ELIGIBLE CLASS(ES):**

[All Employees] in Active Employment in the United States with the Employer.

You must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

[All persons who meet the membership eligibility criteria of the Policyholder.]

[All persons in Active Employment [in the United States] with the Employer.]

[Persons who are not legal residents or citizens of the United States are not eligible for coverage.]

**MINIMUM HOURS REQUIREMENT:**

[30 hours per week]

**WAITING PERIOD:**

[As noted in Your Employer's Group Short Term Disability Income Insurance Policy]

**[REHIRE:**

If Your employment ends and You are rehired within [6] [12] months, Your previous work while in an eligible class will apply toward the Waiting Period. All other policy provisions apply.]

**[WAIVE THE WAITING PERIOD:**

If You have been continuously employed by Your Employer for a period of time equal to Your Waiting Period, We will waive Your Waiting Period when You enter an eligible class.]

**[CREDIT PRIOR SERVICE:**

We will apply any prior period of work with Your Employer toward the Waiting Period to determine Your eligibility date.]

**WHO PAYS FOR THE COVERAGE:**

[Your Employer pays the cost of Your coverage.]

[You and Your Employer share the cost of Your coverage.]

[You pay the cost of Your coverage.]

**[WAIVER OF PREMIUM:**

Premium payments are not required for Your coverage [beginning the first of the month] following [30] [60] consecutive days of disability, and thereafter while You are receiving Short Term Disability payments.]

**ELIMINATION PERIOD:**

[[0- 30] consecutive days for disability due to Injury.

[0- 30] consecutive days for disability due to Sickness.]]

[The latest of:

1. [0-30] consecutive days for disability due to Injury;
2. [0- 30] consecutive days for disability due to a Sickness; or
3. the date Your Salary Continuation or Accumulated Sick Leave payments end, if applicable.]

[If, because of a disability, the Employee is Hospital Confined as an In-Patient, benefits begin immediately [or the date the Employee's Salary Continuation or Accumulated Sick Leave payments end, whichever is later].]

The elimination period begins on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.

**WEEKLY BENEFIT:**

[[40% - 80%] of Weekly Earnings to a Maximum Benefit of [\$100 - \$5,000] per week.]

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered under the policy.

**[MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY:**

[\$100 - \$5,000] per week]

**WEEKLY EARNINGS:**

**(Current income before taxes, including deferred compensation)**

["Weekly Earnings" means Your gross weekly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, renewal commissions, tips and tokens, shift differential, expense reimbursements, bonuses, overtime pay, any other extra compensation, or income received from sources other than Your Employer.

[Weekly Earnings will be averaged for the lesser of:

- a) the 12 full calendar months period of Your employment with Your Employer just prior to the date Your disability begins; or
- b) the period of actual employment with Your Employer]

Earnings, whether for a full year or partial year, will be converted to a weekly amount for the purpose of calculating the Weekly Payment.]

**MAXIMUM PERIOD OF PAYMENT: [9- 52] weeks**

**The above items are only highlights of the policy. For a full description of Your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading Your Certificate of Coverage.]**

## **DEFINITIONS**

**ACTIVE EMPLOYMENT** means You are working for Your Employer for earnings that are paid regularly and that You are performing the Material and Substantial Duties of Your Regular Occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the SCHEDULE OF BENEFITS.

To be in Active Employment, Your work site must be:

1. Your Employer's usual place of business; or
2. an alternative work site at the direction of Your Employer, including Your home; or
3. a location to which Your job requires You to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

**APPROPRIATE CARE** means that You:

1. regularly visit a Doctor as frequently as medically required according to standard medical practice to effectively treat and manage Your disabling condition(s); and
2. receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a Doctor whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
3. have the obligation to minimize Your disabling condition including having corrective treatment or minor surgery.

**CONTEST** means that, if We determine You made a material misrepresentation in Your application for coverage under the policy, We assert in writing that such coverage was therefore never effective. The contest is effective on the date We mail the letter along with a refund of premium.

**DEDUCTIBLE SOURCES OF INCOME** means income from other sources as listed in the policy which You receive or are eligible to receive while You are disabled. This income will be subtracted from Your Gross Weekly Payment.

**[DISABILITY EARNINGS** means the earnings which You receive while You are disabled and working, plus the earnings You could receive if You were working to Your Maximum Capacity.]

**DOCTOR** means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or
4. a person who is a legally qualified medical practitioner according to the Laws and regulations of the governing jurisdiction.

We will not recognize You or Your family members, including but not limited to, spouse, domestic partner, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with You as a Doctor for a claim that You send to Us.

**[ELIGIBLE SURVIVOR** means Your spouse, if living; otherwise, Your children under age 25.]

**[EMPLOYEE** means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.]

(Standard)

**[EMPLOYER** means the Policyholder and includes any division, subsidiary, or affiliated company named in the policy.]

(Alternative)

**[EMPLOYER** means the entity that has been approved by Us for coverage under the policy issued to the Policyholder. Approval by Us of an Employer's plan of coverage under the policy is as recorded and maintained in Our underwriting files(s) for the policy.]

**[ENROLL** means You have completed the process of applying for coverage under the policy.]

**[ENROLLMENT FORM]** means the application You complete and submit to Us to apply for coverage under the policy.]

**[EVIDENCE OF INSURABILITY]** means a statement of Your medical history that We will use to determine if You are approved for coverage. Evidence of Insurability will be provided at Your own expense.]

**[EVIDENCE OF INSURABILITY FORM]** means the portion of the Enrollment Form that You complete and submit to Us that contains a statement of Your medical history.]

**GRACE PERIOD** means the [31-60] day period following the premium due date during which premium payment may be made.

**GROSS WEEKLY PAYMENT** means Your benefit before any reduction for Deductible Sources of Income [and Disability Earnings].

**HOSPITAL, HEALTH FACILITY OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing Your disability.

**[HOSPITAL CONFINED]** means You are confined as an In-Patient in a Hospital, Health Facility or Institution.]

**INJURY** means a bodily Injury that is the direct result of an accident and not related to any other cause. The Injury must occur, and disability resulting from the Injury must begin while You are covered under the policy. Injury that occurs before You are covered under the policy will be treated as a Sickness.

**[IN-PATIENT]** means an individual who is physically confined for an overnight stay, as a registered bed patient in a Hospital, Health Facility or Institution.]

**INSURED** means any person covered under the policy.

**INSURED PERSON** means a person who is eligible for the coverage under this policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.

**LAW, PLAN, or ACT** means the original enactments of the law, plan, or act and all amendments.

**MATERIAL AND SUBSTANTIAL DUTIES** means duties that:

1. are normally required for the performance of Your Regular Occupation; and
2. cannot be reasonably omitted or modified, except that if You are required to work on average in excess of 40 hours per week, We will consider You able to perform that requirement if You have the capacity to work 40 hours per week.

**MAXIMUM BENEFIT** means the total weekly benefit amount for which You are Insured under the policy subject to all policy provisions.

**[MAXIMUM CAPACITY]** means, based on Your restrictions and limitations, the greatest extent of work You are able to do in Your Regular Occupation.]

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time We will make payments to You for any one period of disability.

**OCCUPATIONAL SICKNESS OR INJURY** means a Sickness or Injury that was caused by or aggravated by any employment for pay or profit.

**[PART- TIME BASIS]** means the ability to work and earn from 20% through [75% - 80%] of Your Weekly Earnings. Ability is based on capacity and not market availability.]

**PAYABLE CLAIM** means a claim for which We are liable under the terms of the policy.

**[PRE-EXISTING CONDITION]** means any condition for which You have done [, or for which an ordinarily prudent person would ordinarily have done,] any of the following at any time during the [3-12] months just prior to Your effective date of coverage, whether or not that condition is diagnosed at all or is misdiagnosed:

1. received medical treatment or consultation;
2. taken or were prescribed drugs or medicine; or
3. received care or services, including diagnostic measures.]

(Standard)

**[POLICYHOLDER]** means the Employer to whom the policy is issued and who sponsored the coverage for its **Employees.**]

(Alternative)

**[POLICYHOLDER]** means the entity to whom the policy is issued.]

**RECURRENT DISABILITY** means a disability which is:

1. caused by a worsening in Your condition; and
2. due to the same cause(s) as Your prior disability for which We made a Weekly Payment.

**REGULAR OCCUPATION** means the occupation You are routinely performing when Your disability begins. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

**RETIREMENT PLAN** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to Employees and are not funded entirely by Employee contributions. Retirement Plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

**SALARY CONTINUATION** or **ACCUMULATED SICK LEAVE** means continued payments to You by Your Employer of all or part of Your Weekly Earnings, after You become disabled as defined by the policy. This continued payment must be part of an established plan maintained by Your Employer, and includes Salary Continuation, Accumulated Sick Leave or any similar Employer sponsored paid time off plan.

**SICKNESS** means illness, disease or physical condition. Disability resulting from the Sickness must begin while You are covered under the policy.

**[TEMPORARY LAYOFF or] LEAVE OF ABSENCE** means You are absent from Active Employment for a period of time that has been agreed to in advance in writing by Your Employer.

Your normal vacation time or any period of disability is not considered a [Temporary Layoff] or Leave of Absence.]

**WAITING PERIOD** means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that You must be in Active Employment in an eligible class before You are eligible for coverage under the policy.

**WEEKLY EARNINGS** means Your gross weekly income from Your Employer as stated in the SCHEDULE OF BENEFITS.

**WEEKLY PAYMENT** means Your benefit after any Deductible Sources of Income [and Disability Earnings] have been subtracted from Your Gross Weekly Payment.

**WE, US, and OUR** means Kansas City Life Insurance Company.

**YOU and YOUR** means a person who is eligible for coverage under the policy.

## **GENERAL PROVISIONS**

### **CERTIFICATE OF COVERAGE**

This Certificate of Coverage is a written statement prepared by Us and may include attachments. It tells You:

1. the coverage to which You may be entitled;
2. to whom We will make a payment; and
3. the limitations, exclusions and requirements that apply within the policy.

(Standard)

#### **[ELIGIBILITY DATE**

If You are working for Your Employer in an eligible class, the date You are eligible for coverage is the later of:

1. the policy effective date; or
2. the day after You complete Your Waiting Period.]

(Alternative)

#### **[ELIGIBILITY DATE**

You are eligible for insurance under the policy if:

1. You meet the eligibility criteria of the Policyholder and You are not confined at home, in a hospital, convalescent care facility, a nursing home or elsewhere when the insurance would otherwise become effective, and You can perform all the usual and customary duties or activities of an individual in good health and of the same age and gender; and
2. You are in an eligible class under the policy.]

#### **[WHEN COVERAGE BEGINS**

When Your Employer pays 100% of the cost of Your coverage under the policy, You will be covered at 12:01 a.m. Standard Time at Your Employer's address on the date You are eligible for coverage.

When You and Your Employer share the cost of Your coverage under the policy or when You pay 100% of the cost Yourself, You will be covered at 12:01 a.m. Standard Time at the Policyholder's address on the latest of:

1. the date You are eligible for coverage, if You Enroll for insurance on or before that date;
2. the [first day of the month following the] date You Enroll for insurance, if You Enroll within [31-60] days after the date You become eligible for coverage; or
3. the [first day of the month following the] date We approve Your Enrollment Form, if Evidence of Insurability is required.

In order for Your coverage to begin, You must be in Active Employment. Your coverage is subject to payment of premium.]

### **CHANGES TO YOUR COVERAGE**

Once Your coverage begins, any increased or additional coverage will take effect immediately if You are in Active Employment [or if You are on a covered [Temporary Layoff or] [Leave of Absence]. If You are not in Active Employment due to Injury or Sickness, any increased or additional coverage will begin on the date You return to Active Employment.

Any decrease in coverage will take effect immediately but will not affect a Payable Claim that occurs prior to the decrease.

#### **[WHEN EVIDENCE OF INSURABILITY IS REQUIRED**

Evidence of Insurability is required if:

1. You are a late applicant, which means You Enroll for coverage more than [31-60] days after the date You are eligible for coverage;
2. You voluntarily canceled Your coverage and are reapplying.

An Evidence of Insurability Form can be obtained from Your Employer.]

## **[IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS]**

If You are on a Leave of Absence, and if premium is paid, Your coverage may be continued beyond the date You are no longer in Active Employment, limited to the time periods described below.

If You are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 ("FMLA") or applicable state family and medical leave Law ("State FML"), and Your Employer's Human Resource Policy provides for continuation of disability coverage during a FMLA or State FML Leave of Absence, Your coverage will be continued until the end of the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state Law.

If You are on a Leave of Absence other than a FMLA or State FML Leave of Absence, and if premium is paid, Your coverage will be continued through [the end of the month that immediately follows the month] in which Your Leave of Absence begins.

If You are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state Law, Your coverage may be continued until the end of the later of:

1. the length of time the coverage may be continued under the Certificate of Coverage for a FMLA or State FML Leave of Absence; or
2. the length of time the coverage may be continued under the Certificate of Coverage for a Leave of Absence other than a FMLA or State FML Leave of Absence.

If Your Employer has approved more than one type of Leave of Absence for You during any one period that You are not in Active Employment, We will consider such leaves to be concurrent for the purpose of determining how long Your coverage may continue under the policy.

If Your coverage is not continued during a FMLA or State FML Leave of Absence, and You return to Active Employment immediately following the end of Your FMLA or State FML Leave of Absence, Your coverage will be reinstated. We will not apply a new Waiting Period, [or] require Evidence of Insurability [, or apply a new Pre-Existing Condition limitation].

If Your coverage is not continued during a Leave of Absence for active military service, and You return to Active Employment, Your coverage may be reinstated in accordance with USERRA and applicable state Law.

In no event will Your coverage under the policy be continued beyond the date Your coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.]

## **[IF YOU ARE NOT IN ACTIVE EMPLOYMENT DUE TO A TEMPORARY LAYOFF [OR LABOR STRIKE]**

If You are not in Active Employment due to a Temporary Layoff, and if premium is paid, You will be covered through the [end of the month that immediately follows the month] in which Your Temporary Layoff begins.

[If You are not in Active Employment due to a labor strike, and if premium is paid, You will be covered through [the end of the month that immediately follows the month] in which the labor strike begins.]]

## **WHEN YOUR COVERAGE ENDS**

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled;
2. the date You are no longer in an eligible class;
3. the date Your eligible class is no longer covered;
4. the end of the Grace Period after a premium due date, if premium is not paid; or
5. the last day You are in Active Employment [except as provided under a covered Leave of Absence [[or] [,] Temporary Layoff [,] [or labor strike]].

We will provide coverage for a Payable Claim that occurs while You are covered under the policy.

## **TIME LIMITS FOR LEGAL PROCEEDINGS**

You can start legal action regarding Your claim 60 days after proof of claim has been given to Us, and up to three years from the time proof of claim is required, unless otherwise provided under federal Law.

## **STATEMENTS MADE IN AN APPLICATION FOR COVERAGE**

We consider any statements the Policyholder [, Your Employer,] and You make in an application representations and not warranties. No statements made by You will be used to reduce or deny any claim or to cancel Your coverage unless:

1. the statement is in writing and is signed by You; and
2. a copy of that statement is given to You or Your beneficiary.

## **TIME LIMIT ON CERTAIN DEFENSES**

Except in the case of fraud, no statement made by You relating to Your insurability will be used to Contest the insurance for which the statement was made after the coverage has been in force for two years.

[Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no] [No] claim for disability with respect to which the claim is made, shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

## **CLERICAL ERROR**

Clerical error or omission by Us [or][,] the Policyholder [,or Your Employer] will not:

1. prevent You from receiving coverage, if You are entitled to coverage under the terms of the policy; or
2. cause coverage to begin or continue for You when the coverage would not otherwise be effective.

If the Policyholder [or Your Employer] gives Us information about You that is incorrect, We will:

1. use the facts to decide whether You have coverage under the policy and in what amounts; and
2. make a fair adjustment of the premium.

## **MISSTATEMENT OF AGE**

If premiums applicable to You are based on age and You have misstated Your age, there will be a fair adjustment of premiums based on Your true age. If the benefits applicable to You are based on age and You have misstated Your age, there will be an adjustment of said benefits based on Your true age. We may require satisfactory proof of Your age before paying any claim.

## **WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE**

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

## **AGENCY**

For purposes of the policy, the Policyholder [and Your Employer] acts on [its][their] own behalf or as Your agent. Under no circumstances will the Policyholder [or Your Employer] be deemed Our agent.

## **SHORT TERM DISABILITY BENEFIT INFORMATION**

### **DEFINITION OF DISABILITY**

#### **(Total)**

[You are considered disabled when We review Your claim and determine that due to Your Sickness or Injury, You are unable to perform the Material and Substantial Duties of Your Regular Occupation, and You are not working in any occupation.]

#### **(Partial with both loss of duties and earnings loss)**

[You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation;
2. You have a 20% or more loss in Your Weekly Earnings; and
3. during the elimination period, You are unable to perform any of the Material and Substantial Duties of Your Regular Occupation, and You are not working in any occupation.]

#### **(Partial Regular Occupation with either loss of duties or earnings loss)**

[You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation; or
2. Your Disability Earnings if any, are less than [75% - 80%] of Your Indexed Weekly Earnings; and
3. during the elimination period, You are unable to perform any of the Material and Substantial Duties of Your Regular Occupation, and You are not working in any occupation.]

#### **(Residual with both loss of duties and earnings loss)**

[You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation; and
2. You have a 20% or more loss in Your Weekly Earnings.]

#### **(Residual Regular Occupation with either loss of duties or earnings loss)**

[You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation; or
2. Your Disability Earnings if any, are less than [75% - 80%] of Your Indexed Weekly Earnings.]

#### **(For all plans)**

The loss of a professional or an occupational license or certification does not, in itself, constitute disability.

You must be under the Appropriate Care of a Doctor in order to be considered disabled.

We may require You to be examined by one or more Doctors, other medical practitioners, or vocational experts of Our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require You to be interviewed by Our authorized representative. Your failure to comply with this request may result in denial or termination of benefits.

### **[(Total disability, Partial disability) ELIMINATION PERIOD**

You must be continuously totally disabled through Your elimination period. Your elimination period is as stated in the SCHEDULE OF BENEFITS and is the period of continuous disability You must satisfy before You are eligible to receive benefits under the policy.

If Your disability stops during the elimination period, We will not consider Your disability to be continuous.

The elimination period begins on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.]

## **[(Residual disability) ELIMINATION PERIOD]**

You must be continuously disabled through Your elimination period. Your elimination period is as stated in the SCHEDULE OF BENEFITS and is the period of continuous disability You must satisfy before You are eligible to receive benefits under the policy.

The elimination period begins on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.]

## **WHEN YOU RECEIVE PAYMENTS**

You will begin to receive payments when We approve Your claim, providing the elimination period has been met and You are disabled. We will send You a Weekly Payment at the end of each week for any period for which We are liable.

After the elimination period, if You are disabled for less than 1 week, We will send You 1/7<sup>th</sup> of Your Weekly Payment for each day of Your disability.

## **AMOUNT OF PAYMENT**

### **[A. IF YOU ARE DISABLED AND NOT WORKING [, OR DISABLED AND WORKING AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR WEEKLY EARNINGS]]**

#### **(Direct)**

[We will follow this process to figure Your payment:

1. Multiply Your Weekly Earnings by [40 - 80%].
2. The Maximum Benefit is [\$100 - \$5,000] per week.
3. Compare the answer from Item 1 with the Maximum Benefit. The lesser of these two amounts is Your Gross Weekly Payment.
4. Subtract from Your Gross Weekly Payment any Deductible Sources of Income.

The amount figured in Item 4 is Your Weekly Payment.]

#### **[(70%-100%) All Sources]**

[We will follow this process to figure Your payment:

1. Multiply Your Weekly Earnings by [40% - 80%].
2. The Maximum Benefit is [\$100 - \$5,000] per week.
3. Compare the answer from Item 1 with the Maximum Benefit. The lesser of these two amounts is Your Gross Weekly Payment.
4. Multiply Your Weekly Earnings by [70% -100%] and subtract any Deductible Sources of Income except income from any form of employment.
5. Compare the answer from Item 3 and Item 4.

The lesser amount figured in Item 5 is Your Weekly Payment.]

#### **(Regular Occupation with both loss of duties and earnings loss)**

### **[B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO [75% - 80%] OF YOUR WEEKLY EARNINGS]**

#### **(Regular Occupation with either loss of duties or earnings loss)**

### **[B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% OF YOUR WEEKLY EARNINGS]**

## **(DIRECT –Proportionate Loss or 50% offset)**

#### **(Proportionate loss formula)**

You will receive payments based on the percentage of income You are losing due to Your Disability. We will follow this process to determine Your Weekly Payment:

1. Subtract Your Disability Earnings from Your Weekly Earnings.

2. Divide the answer in Item 1 by Your Weekly Earnings. The result is Your percentage of lost earnings.
3. From Your Gross Weekly Payment, subtract any Deductible Sources of Income.
4. Multiply the answer in Item 2 by the answer in Item 3.]

The answer in Item 4 is Your Weekly Payment.]

**(50% offset formula)**

[Your Weekly Payment will be reduced by 50% of Your Disability Earnings. We will follow this process to determine Your Weekly Payment:

1. Multiply Your Disability Earnings by 50%.
2. From Your Gross Weekly Payment, subtract the answer in Item 1 and any Deductible Sources of Income.

The answer in Item 2 is Your Weekly Payment.]

**[C. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN [75% - 80%] OF YOUR WEEKLY EARNINGS**

If You are working and Your Disability Earnings are more than [75% - 80%] of Your Weekly Earnings, no benefit will be payable.]

If You are able to perform all the Material and Substantial Duties of Your Regular Occupation and Your Disability Earnings are more than [75%-80%] of Your Weekly Earnings, no benefit will be payable.

**(For all plans)**

[We may require You to send proof of Your weekly Disability Earnings each week. We will adjust Your payment based on Your weekly Disability Earnings.

As part of Your proof of Disability Earnings, we can require that You send Us appropriate financial records that We believe are necessary to substantiate Your income.]

After the elimination period, if You are disabled for less than 1 week, We will send You 1/7<sup>th</sup> of Your Weekly Payment for each day of disability.

**[IF YOUR DISABILITY EARNINGS FLUCTUATE**

If Your Disability Earnings routinely fluctuate widely from week to week, We may average Your Disability Earnings over the most recent three weeks to determine if Your claim should continue.

If We average Your Disability Earnings, We will not terminate Your claim unless the average of Your Disability Earnings from the last three weeks exceeds [75% - 80%] of Your Weekly Earnings.

We will not pay You for any week during which Your Disability Earnings exceed the amount allowable under the policy. In no event will benefits be paid beyond the Maximum Period of Payment.]

**DEDUCTIBLE SOURCES OF INCOME**

The following are Deductible Sources of Income:

1. The amount that You receive, or are eligible to receive, as disability income payments under any:
  - a. state compulsory benefit Act or Law;
  - b. [individual disability income plans which are paid for by the Policyholder and purchased on or after the effective date of this policy;]
  - c. automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable;
  - d. military disability benefit plan;
  - e. governmental retirement system as a result of Your job with Your Employer; or
  - f. other group insurance policy.
2. The amount You receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).

3. The amount You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, [not to exceed 50% of the net settlement].
- [4. The amount You receive under any Salary Continuation or Accumulated Sick Leave plan.]
5. The amount that You:
- a. receive as disability payments under Your Employer's Retirement Plan;
  - b. voluntarily elect to receive as retirement payments under Your Employer's Retirement Plan; or
  - c. are eligible to receive as retirement payments when You reach the later of age 62 or normal retirement age, as defined in Your Employer's Retirement Plan.

Disability payments under a Retirement Plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are paid based on Your Employer's contribution to the Retirement Plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the Retirement Plan are distributed, We will consider the Employer and Employee contributions to be distributed simultaneously throughout Your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible Retirement Plan. We will use the definition of eligible Retirement Plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

(For Primary & Family Integration)

- [6. The amount that You, Your spouse, and Your children receive, or are eligible to receive, as disability payments because of Your disability under:
- a. the United States Social Security Act;
  - b. the Canada Pension Plan;
  - c. the Quebec Pension Plan; or
  - d. any similar Plan or Act.
7. The amount that You receive as retirement payments or the amount Your spouse and Your children receive as retirement payments because You are receiving retirement payments under:
- a. the United States Social Security Act;
  - b. the Canada Pension Plan;
  - c. the Quebec Pension Plan; or
  - d. any similar Plan or Act.]

(For Primary Integration only)

- [6. The amount that You receive or are eligible to receive as disability payments under:
- a. the United States Social Security Act;
  - b. the Canada Pension Plan;
  - c. the Quebec Pension Plan; or
  - d. any similar Plan or Act.

We will not offset with any amount received by Your spouse or dependents.]

- [7. The amount that You receive as retirement payments under:
- a. the United States Social Security Act;
  - b. the Canada Pension Plan;
  - c. the Quebec Pension Plan; or
  - d. any similar Plan or Act.

We will not offset with any amount received by Your spouse or dependents.]

[8. The amount You earn or receive from any form of employment.]

[9. The amount You receive from any unemployment compensation Law.]

[10. The amount that You receive, or are eligible to receive, under:

- a. a workers' compensation Law;
- b. an occupational disease Law; or
- c. any other Act or Law with similar intent.]

With the exception of retirement payments, We will only subtract Deductible Sources of Income which are payable as a result of the same disability.

We will not reduce Your payment by Your Social Security retirement income if Your disability begins after age 65 and You were already receiving Social Security retirement payments.

### **IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME**

When We determine that You may qualify for benefits for which You are eligible in the Deductible Sources of Income section, We will estimate Your entitlement to these benefits. We can reduce Your benefit under the policy by the estimated amounts if such benefits:

1. have not been awarded or denied; or
2. have been denied and the denial is being appealed.

Your Gross Weekly Payment will NOT be reduced by the estimated amount if You:

1. apply for the disability payments for which You are eligible in the Deductible Sources of Income section and appeal Your denial to all administrative levels We determine are necessary; and
2. sign Our form. This form states that You promise to pay Us any overpayment caused by an award and We shall be entitled to impose a constructive trust on any such award.

If Your Gross Weekly Payment has been reduced by an estimated amount, Your Gross Weekly Payment will be adjusted when We receive proof:

1. of the amount awarded; or
2. that benefits have been denied and all appeals We determine are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to You.

If You receive a lump sum payment from any Deductible Source of Income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis from the date of the award over Your expected lifetime as determined by Us.

### **NON-DEDUCTIBLE SOURCES OF INCOME**

We will not subtract from Your Gross Weekly Payment income You receive from, the following:

1. 401(k) plans;
2. [Salary Continuation or Accumulated Sick Leave plans;]
3. profit sharing plans;
4. thrift plans;
5. tax-sheltered annuities;
6. stock ownership plans;
7. credit disability insurance;
8. non-qualified plans of deferred compensation;
9. pension plans for partners;
10. military pension plans;
11. franchise disability income plans;
12. individual disability plans paid for by the Insured Person;
13. a Retirement Plan from another employer;

14. individual retirement accounts (IRA).

## **MINIMUM PAYMENT**

The minimum payment each week for a Payable Claim is [the greater of:

1. ][\$25] [\$50] [\$100][.]; or
2. [5%-30%] of Your Gross Weekly Payment.]

We may apply this amount to recover an outstanding overpayment.

## **DURATION OF PAYMENTS**

We will send You a payment each week up to the Maximum Period of Payment. Your Maximum Period of Payment is stated in the SCHEDULE OF BENEFITS and will be paid during a continuous period of disability.

## **WHEN PAYMENTS END**

### **(Total)**

[We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer disabled under the terms of the policy;
3. the date You fail to submit proof of continuing disability; or
4. the date You die.]

[We will not pay a benefit for any period of disability during which You are incarcerated.]

### **(Partial or Residual with both loss of duties or earnings loss)**

[We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer disabled under the terms of the policy;
3. the date You fail to submit proof of continuing disability;
4. the date You die;
5. when You are able to return to work in Your Regular Occupation on a Part-Time Basis but You do not; or
6. the date Your Disability Earnings exceed [75% - 80%] of Your Weekly Earnings.]

[We will not pay a benefit for any period of disability during which You are incarcerated.]

### **(Partial or Residual Regular Occupation with either loss of duties or earnings loss)**

[We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer disabled under the terms of the policy;
3. the date You fail to submit proof of continuing disability; or
4. the date You die.]

[We will not pay a benefit for any period of disability during which You are incarcerated.]

## **DISABILITIES NOT COVERED UNDER THE POLICY**

The policy does not cover any disabilities caused by, contributed to by, or resulting from Your:

1. loss of professional license, occupational license, or certification;
2. participation in a felony;
3. intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;[
5. being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor;]

6. participation in a war, declared or undeclared, or any act of war;
7. active military duty;
8. active participation in a riot;
9. engaging in any illegal or fraudulent occupation, work, or employment;
10. commission of a crime for which You have been convicted;
11. elective surgery except when required for Your Appropriate Care as a result of Your Injury or Sickness; or
12. traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes[.]; or
13. Occupational Sickness or Injury.]

#### **[PRE-EXISTING CONDITION LIMITATION**

[Benefits will not be paid if Your disability begins in the first [12-24] months following the effective date of Your coverage and Your disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which[:

1. ]You received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the [3-12] months just prior to Your effective date of coverage[.][: or
2. You had symptoms for which an ordinarily prudent person would have consulted a Doctor in the [3-12] months just prior to Your effective date of coverage.]]

[Benefits will not be paid if Your disability begins in the first [12-24] months following the effective date of Your coverage and Your disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the [3-12] months just prior to Your effective date of coverage [; or
2. You had symptoms for which an ordinarily prudent person would have consulted a Doctor in the [3-12] months just prior to Your effective date of coverage]; and
3. You were not Treatment Free for [6-12] consecutive months after Your effective date of coverage].

[If there is an increase in the Maximum Benefit after the Policy Effective Date, this PRE-EXISTING CONDITION LIMITATION provision will apply to the amount of the increase in the Maximum Benefit, as of the effective date of the increase.]

#### **RECURRENT DISABILITY**

If You have a Recurrent Disability, and after Your prior disability ended, You returned to work for Your Employer for 14 days or less, We will treat Your disability as part of Your prior claim and You do not have to complete another elimination period.

Your Weekly Payment will be based on Your Weekly Earnings as of the date of Your initial claim.

Your disability, as outlined above, will be subject to the same terms of this policy as Your prior claim.

Your disability will be treated as a new claim if Your current disability:

1. is unrelated to Your prior disability; or
2. after Your prior disability ended, You returned to work for Your Employer for more than 14 consecutive days.

The new claim will be subject to all of the provisions of the policy and You will be required to satisfy a new elimination period.

If Our policy terminates and You become eligible for payments under any other group disability plan that replaces Our policy, You will not be eligible for payments under Our policy.

#### **[BENEFITS IF YOU DIE - SURVIVOR BENEFIT**

When We receive proof that You have died, We will pay Your Eligible Survivor a lump sum benefit equal to [1-3] times Your [last] [Gross ] Weekly Benefit if, on the date of Your death:

1. Your disability had continued for [30 - 60] or more consecutive days; and

2. You were receiving or were eligible to receive payments under the policy.

If You have no Eligible Survivors, payment will be made to Your estate, unless there is none. In this case, no payment will be made.

However, We will first apply the Survivor Benefit to recover any overpayment that may exist on Your claim.]

**[IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY (Continuity of Coverage)]**

If You are not in Active Employment due to Injury [,][or] Sickness [,or] [Leave of Absence] [or Temporary Layoff] on the date Your Employer changes insurance carriers to Our policy, and You were covered under the prior policy at the time Your Employer's coverage under Our policy became effective, We will provide continuity of coverage under Our policy. In order for this provision to apply, the prior policy's coverage must be similar to Our policy.

If You are not in Active Employment due to Injury [,][or] Sickness [,or] [Leave of Absence] [or Temporary Layoff] on the effective date of Our policy, and You would otherwise be eligible to become Insured under Our policy, We will provide limited coverage under Our policy. Coverage under this provision will begin on Our [policy effective date and will continue until the earliest of:

1. the [end of the month following the] date You return to Active Employment; or
2. the end of any period of continuance or extension provided under the prior policy; or
3. the date coverage would otherwise end, according to the provisions of Our policy.

Your coverage under this provision is subject to payment of premium.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. We will reduce Your payment by any amount for which the prior carrier is liable.

If coverage ends under this provision, or if You were not covered under Your Employer's prior policy on the date that policy terminated, the WHEN COVERAGE BEGINS provision under Our policy will apply.]

**[IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY (Continuity of Coverage)]**

We may send a payment if Your disability is caused by, contributed by or results from a Pre-Existing Condition if:

1. You were Insured by the prior policy at the time Your Employer changed insurance carriers to Our policy; and
2. You have been continuously covered under Our policy from the effective date of Your Employer's policy through the date Your disability began.

In order to receive a payment, You must satisfy the Pre-Existing Condition provision under:

1. Our policy; or
2. the prior policy, if benefits would have been paid had that policy remained in force.

If You satisfy the Pre-Existing Condition provision of Our policy, We will determine Your payments according to Our policy's provisions.

If You do not satisfy the Pre-Existing Condition provision of this policy, but You do satisfy the prior policy's Pre-Existing Condition provision:

1. Your Weekly Payment will be the lesser of:
  - a. the Weekly Payment that would have been payable under the terms of the prior policy if it had remained in force;  
or
  - b. the Weekly Payment under Our policy; and
2. benefits will end on the earlier of:
  - a. the date benefits end under Our policy, as described under the DURATION OF PAYMENTS provision; or
  - b. the date benefits would have ended under the prior policy if it had remained in force.

If You do not satisfy either Our policy's or the prior policy's Pre-Existing Condition provision, We will not make any payments.

We will require proof that You were Insured under the prior policy.

All other provisions of Our policy will apply.]

## **SHORT TERM DISABILITY CLAIM INFORMATION**

### **NOTICE OF CLAIM**

We encourage You to notify Us of Your claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be given to Us within 30 days after the date Your disability begins. The notice may be given to Us at Our home office or to Our authorized agent. Failure to give notice within this timeframe shall not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

The claim form is available from [the Policyholder][Your Employer], or You can request a claim form from Us. If You do not receive the form from Us within 15 days of Your request, send Us written proof of claim without waiting for the form.

You must notify Us immediately when You return to work in any capacity.

### **FILING A CLAIM**

You and Your Employer must fill out Your own sections of the claim form and then give it to Your attending Doctor. Your Doctor should fill out his or her section of the form and send it directly to Us.

### **PROOF OF YOUR CLAIM**

You must send Us written proof of Your claim no later than 90 days after Your elimination period. Failure to give such proof within this timeframe shall not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. You must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Your proof of claim, provided at Your expense, must show:

1. that You are under the Appropriate Care of a Doctor;
2. the date Your disability began;
3. the cause of Your disability;
4. the appropriate documentation of Your earnings and Your activities;
5. the extent of Your disability, including restrictions and limitations preventing You from performing Your Regular Occupation;
6. the name and address of any Hospital, Health Facility or Institution where You received treatment, including all attending Doctors; and
7. documentation of prior disability coverage, if applicable.

In some cases, You will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of Your proof of claim, or proof of continuing disability. We will deny Your claim, or stop sending You payments, if the appropriate information is not submitted within 45 days of the request.

You or Your Employer must notify Us immediately when You return to work in any capacity.

### **MAKING PAYMENTS**

Once Your claim has been approved, We will send You a payment at the end of each week for any period for which We are liable.

### **OVERPAID CLAIMS**

We have the right to recover any overpayments due to:

1. fraud;
2. any administrative error We make in processing a claim; or
3. Your receipt of Deductible Sources of Income.

You must reimburse Us in full. We will determine the method by which the repayment is to be made.

We will not recover more money than the amount We paid You. However, We reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.



**KANSAS CITY LIFE  
INSURANCE COMPANY**

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GROUP LONG TERM DISABILITY INSURANCE POLICY  
NON-PARTICIPATING

---

POLICYHOLDER:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICY ANNIVERSARY DATE: [A date established and agreed to by the Policyholder and Us]

GOVERNING JURISDICTION:

Kansas City Life Insurance Company (referred to as Kansas City Life) will provide benefits under this policy. Kansas City Life makes this promise subject to all of this policy's provisions.

The Policyholder should read this policy carefully and contact Kansas City Life promptly with any questions. This policy is delivered in and is governed by the Laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This entire policy consists of:

1. all policy provisions and any amendments and/or attachments issued;
2. the Certificate of Coverage; and
3. the Policyholder's signed application[.]; and
4. the Employers' signed participation agreements; and]
5. the Insured Persons' signed Enrollment Forms.]

This policy may be changed in whole or in part. Only an officer [or registrar] of Kansas City Life can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, PO Box 219425, Kansas City, MO 64121-9425.

Secretary

President, CEO and Chairman

**KANSAS CITY LIFE INSURANCE COMPANY**  
3520 Broadway, Kansas City, MO 64111  
816-753-7000



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## **POLICYHOLDER PROVISIONS**

### **INCONTESTABILITY**

The validity of the policy shall not be contested after the policy has been in effect for two years except in situations when:

1. premium has not been paid; or
2. for fraudulent misrepresentations.

**[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDED][PARTICIPATING EMPLOYERS]:**

**NAME LOCATION (CITY AND STATE)**

[None]

**[XYZ Company] [City, State]**

### **ELIGIBLE CLASS(ES):**

[All Employees] in Active Employment in the United States with the Employer.

Employee must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

[All persons who meet the membership eligibility criteria of the Policyholder].

[All persons in Active Employment [in the United States] with the Employer.]

[Persons who are not legal residents or citizens of the United States are not eligible for coverage.]

### **MINIMUM HOURS REQUIREMENT:**

[30 hours per week]

### **WAITING PERIOD:**

For persons in an eligible class on or before the policy effective date: [None]

[A continuous period of [1-365 days] of Active Employment.]

[End of the month in which the Employee completes a continuous period of [1-365 days] of Active Employment.]

For persons entering an eligible class after the policy effective date:

[A continuous period of [1-365 days] of Active Employment.]

[End of the month in which the Employee [completes a continuous period of [1-365 days]][begin] of Active Employment.]

### **COST OF INSURANCE**

The initial premium for the policy is based on the initial rate(s) shown below.

[[Monthly] [Quarterly] rate of [x%] of [Monthly Covered Payroll] [Monthly Benefit]]

[[Monthly] [Quarterly] rate of [\$xx.xx] [per \$100 of [Monthly Benefit] [Monthly Covered Payroll]]

[[Monthly] [Quarterly] cost of [\$xxxx.xx] [per Insured Person]]

(Step Rates)

Age	[Monthly][Quarterly] rate per \$100 of [Monthly Benefit] [Monthly Covered Payroll]
Less than age 25	xx.xx
25-29	xx.xx
30-34	xx.xx
35-39	xx.xx
40-44	xx.xx
45-49	xx.xx
50-54	xx.xx

55-59	xx.xx
60-64	xx.xx
65-69	xx.xx
70 and over	xx.xx]

[**MONTHLY COVERED PAYROLL** means the total amount of Monthly Earnings for which Employees are insured under the policy.]

## **INITIAL RATE GUARANTEE AND RATE CHANGES**

A change in premium rates will not take effect before [MM/DD/YYYY] (Rate Guarantee Period).

However, We may change premium rates at any time for reasons which affect the risk assumed, including but not limited to those reasons shown below:

1. a change occurs in this policy design;
2. the number of Insureds changes by [10%-25%] or more; or
3. a new Law or a change in any existing Law is enacted which applies to this policy.

We will notify the Policyholder in writing at least [30-60] days before a premium rate is changed. A change may take effect on an earlier date when both the Policyholder and We agree.

## **WHEN PREMIUM IS DUE**

Premium Due Dates: [MM/DD/YYYY] and the [first day] of each [calendar month] thereafter.

The Policyholder must send all premiums to Us on or before their respective due date. The premium must be paid in United States dollars.

## **PREMIUM INCREASES OR DECREASES**

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

Premium charges for new Insured Persons or for increases in insurance amounts will begin on the premium due date which coincides with or next follows the date of the addition or the change. Premium charges for terminated persons will end, and decreases for insurance amounts will begin, on the premium due date which coincides with or next follows the termination or the change in amount. This method of charging premium will neither commence any insurance after the date it would otherwise begin nor extend any insurance coverage beyond the date it would otherwise terminate pursuant to the applicable effective date or termination provisions of the policy.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

We will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

## **WAIVER OF PREMIUM**

We do not require premium payment while the Insured Person is receiving Long Term Disability payments under this policy.

(Standard)

## **[INFORMATION REQUIRED FROM THE POLICYHOLDER**

The Policyholder must provide Us with the following on a regular basis:

1. information about persons:
  - a. who are eligible to become insured; and
  - [b.] [who Enroll for coverage [and their initial amount of coverage];]
  - c. whose amounts of coverage change; and

- d. whose coverage ends;
2. occupational and salary information and any other information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in Our opinion, on this policy will be available for review by Us at any reasonable time as determined by Us.]

(Alternative)

#### **[INFORMATION REQUIRED FROM THE POLICYHOLDER]**

The Policyholder must provide Us with detailed information about persons who are eligible to become insured under this policy, information about Insured Persons, and any other information that may be reasonably required.

Policyholder [and Employer] records that have a bearing, in Our opinion, on this policy will be available for review by Us at any reasonable time as determined by Us.]

#### **INFORMATION PROVIDED BY US**

We will furnish the Policyholder with a Certificate of Coverage which outlines the benefits under this policy. The [Policyholder][Employer] will distribute a Certificate of Coverage to each Insured Person.

(Standard)

#### **[AMENDING OR CANCELING THE POLICY]**

This policy can be canceled:

1. by Us; or
2. by the Policyholder.

We may amend or cancel this policy if:

1. [there is less than [5%-100%] participation of those eligible persons who pay all or part of their premium for the policy;]  
[there is less than 100% participation of those eligible persons working for a Policyholder with 3 to 5 eligible persons ];
2. the participation requirement is not met for a Policyholder with 6 to 9 eligible persons who pay a part of their premium for the policy:

<u>Eligible Persons</u>	<u>Participation Requirement</u>
6	5 enrolled
7	6 enrolled
8	6 enrolled
9	7 enrolled]
3. there is less than 100% participation of those eligible persons for a Policyholder paid plan;
4. the Policyholder does not promptly provide Us with information that is reasonably required;
5. the Policyholder fails to perform any of its obligations that relate to this policy;
6. fewer than [2-10] persons are insured under the policy;
7. the premium is not paid in accordance with the provisions of this policy;
8. the Policyholder does not promptly report to Us the names of any persons who are added or deleted from the eligible class(es);
9. We determine that there is a significant change, in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its persons ; or
10. the Policyholder fails to pay any portion of the premium within the [31-60] day Grace Period.

We reserve the right to review and terminate all class(es) covered under the policy if any class(es) cease(s) to be covered.

If We amend or cancel this policy for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least [30-60] days prior to the amendment date or cancellation date. The Policyholder may cancel this policy if the amendments are unacceptable.

If any portion of the premium is not paid during the Grace Period, the policy will terminate automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period. The Policyholder must pay Us all premium due for the full period the policy is in force.

The Policyholder may cancel this policy by written notice delivered to Us at least [30-60] days prior to the cancellation date. When both the Policyholder and We agree, this policy can be canceled on an earlier date. If the Policyholder or We cancel this policy, coverage will end at 12:00 midnight Standard Time at the Policyholder's address on the last day of coverage.

If this policy is canceled, the cancellation will not affect a Payable Claim.]

(Alternative)

**[CANCELING THE POLICY [OR AN EMPLOYER'S PLAN OF COVERAGE UNDER THE POLICY]**

This policy [or an Employer's plan of coverage under the policy] can be canceled:

1. by Us; or
2. by the Policyholder.

We may cancel this policy [or an Employer's plan of coverage under the policy] on any premium due date after the first policy Anniversary Date by giving at least [30-60] days advance written notice of termination to the Policyholder.

If fewer than [10-500] persons are insured under the policy [or an Employer's plan of coverage under the policy], We may cancel this policy [or an Employer's plan of coverage under the policy] at any time by giving at least [30-60] days advance written notice of termination to the Policyholder.

We reserve the right to review and terminate all class(es) covered under the policy if any class(es) cease(s) to be covered.

If any portion of the premium is not paid during the [31-60] day Grace Period, the policy will terminate automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period. The Policyholder must pay Us all premium due for the full period the policy is in force.

The Policyholder may cancel this policy [or an Employer's plan of coverage under the policy] by written notice delivered to Us at least [30-60] days prior to the cancellation date. When both the Policyholder and We agree, this policy [or an Employer's plan of coverage under the policy] can be canceled on an earlier date. If the Policyholder or We cancel this policy [or an Employer's plan of coverage under the policy], coverage will end at 12:00 midnight Standard Time at the Policyholder's address on the last day of coverage.

If this policy [or an Employer's plan of coverage under the policy] is canceled, the cancellation will not affect a Payable Claim.]

(Alternative)

**[AMENDING OR CANCELING THE POLICY [OR AN EMPLOYER'S PLAN OF COVERAGE UNDER THE POLICY]**

This policy [or an Employer's plan of coverage under the policy] can be canceled:

1. by Us; or
2. by the Policyholder.

We may amend or cancel this policy [or an Employer's plan of coverage under the policy] if:

1. the Policyholder [or Employer] does not promptly provide Us with information that is reasonably required;
2. the Policyholder fails to perform any of its obligations that relate to this policy;
3. fewer than [10-500] persons are insured under the policy;
4. the premium is not paid in accordance with the provisions of this policy;
5. We determine that there is a significant change, in the size, occupation or age of the eligible class(es); or
6. the Policyholder fails to pay any portion of the premium within the [31-60] day Grace Period.

We reserve the right to review and terminate all class (es) covered under the policy if any class(es) cease(s) to be covered.

If We amend or cancel this policy [or an Employer's plan of coverage under the policy] for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least [30-60] days prior to the amendment date or cancellation date. The Policyholder may cancel this policy [or an Employer's plan of coverage under the policy] if the amendments are unacceptable.

If any portion of the premium is not paid during the Grace Period, the policy will terminate automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period. The Policyholder must pay Us all premium due for the full period the policy is in force.

The Policyholder may cancel this policy [or an Employer's plan of coverage under the policy] by providing written notice to Us at least [30-60] days prior to the cancellation date. When both the Policyholder and We agree, this policy [or an Employer's plan of coverage under the policy] can be canceled on an earlier date. If the Policyholder or We cancel this policy [or an Employer's plan of coverage under the policy], coverage will end at 12:00 midnight Standard Time at the Policyholder's address on the last day of coverage.

If this policy [or an Employer's plan of coverage under the policy] is canceled, the cancellation will not affect a Payable Claim.]

#### **[ASSIGNMENT]**

The Policyholder may assign the policy, however the Policyholder is required to advise all certificateholders of any assignment in writing, via certified mail. None of the Insured Persons' rights will be affected. Such assignment will not affect Us until We receive written notice at Our home office and give Our written approval.]

#### **[BUSINESS PROTECTION BENEFIT]**

If an Insured Person is receiving a Monthly Payment under this policy, and the Insured Person is:

1. a sole proprietor of the Employer if the Employer is a sole proprietorship; or
2. a general partner of the Employer if the Employer is a partnership; or
3. a member of a limited liability company if the Employer is a limited liability company,

an additional Monthly Benefit will be paid to the Employer to compensate for business revenue lost as a result of that Insured Person's disability.

The Insured Person's elimination period for the Business Protection Benefit is the greater of:

1. the elimination period for the Long Term Disability policy; or
2. 90 consecutive days.

The amount of the Business Protection Benefit payment is the Monthly Payment the Insured Person is receiving under the Long Term Disability policy; however, the Business Protection Benefit will not be reduced by Deductible Sources of Income.

The additional Business Protection Benefit will end on the earliest of:

1. the date the Insured Person is no longer disabled;
2. the date the Insured Person ceases to be a sole proprietor, general partner, member of a limited liability company; or
3. the date the Business Protection Benefit has been paid for [3-60] months.

(Used when Pre-existing condition limitation provision applies)

[The PRE-EXISTING LIMITATION provision of the Long Term Disability policy applies to this Business Protection Benefit, as of the effective date of the Business Protection Benefit coverage for each Insured Person.]

(Used if Evidence of Insurability required)

[In order for the Policyholder to receive a Business Protection Benefit for an Insured Person, that person must submit an Evidence of Insurability Form to Us for approval. The Business Protection Benefit coverage for that person will become effective on the later of:

1. the date the Business Protection Benefit has been added to the policy; or
2. the date We approve the Business Protection Benefit coverage for that person.]

## **[TEMPORARY WORK BENEFIT**

We will pay the Employer a one-time benefit of \$1,000 to be used to supplement the cost of a temporary worker when an Insured Person under this policy is disabled and receiving disability benefits from Us.

The Employer qualifies for this Temporary Work Benefit when:

1. an Insured Person is disabled according to the terms of this policy;
2. the Insured Person has satisfied the elimination period for this policy; and
3. the Insured Person's claim is approved and the Insured Person is receiving disability benefits under this policy;

This one-time payment will be made to the Employer no later than 90 days following the date the first disabled Insured Person under the policy receives his or her first Long Term Disability payment under this policy.

The Temporary Work Benefit is only used once during the life of the policy, including any renewals.

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# GROUP INSURANCE BENEFITS

**Group Name**

**Long Term Disability Insurance**



**KANSAS CITY LIFE  
INSURANCE COMPANY**

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**KANSAS CITY LIFE  
INSURANCE COMPANY**

**GROUP LONG TERM DISABILITY INCOME INSURANCE  
CERTIFICATE OF COVERAGE**

POLICYHOLDER:

POLICY NUMBER:

POLICYHOLDER EFFECTIVE DATE:

[EMPLOYER:]

[EMPLOYER PLAN EFFECTIVE DATE:]

[EMPLOYER IDENTIFICATION NUMBER:]

GOVERNING JURISDICTION:

Kansas City Life Insurance Company (referred to as Kansas City Life) welcomes You as a certificateholder.

**This is Your Certificate of Coverage as long as You are eligible for coverage and You become insured. You will want to read it carefully and keep it in a safe place.**

We have written Your Certificate of Coverage in understandable terms. However, a few terms and provisions are written as required by insurance Law. If You have any questions about any of the terms and provisions, please consult Our claims paying office. We will assist You in any way to help You understand Your benefits.

If the terms and provisions of the Certificate of Coverage (issued to You) are different from the policy (issued to the Policyholder), the policy will govern. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the Laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, We have discretionary authority within the reasonable limits established by the Law to determine Your eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. Standard Time at the Policyholder's address and end at 12:00 midnight Standard Time at the Policyholder's address.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, PO Box 219425, Kansas City, MO 64121-9425.

Secretary

President, CEO and Chairman

**The policy [covers][does not cover] disabilities due to an occupational Sickness or Injury.**

**The policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.**

**CERTIFICATE OF COVERAGE**  
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## **SCHEDULE OF BENEFITS**

### **LONG TERM DISABILITY**

The Long Term Disability policy provides financial protection for You by paying a portion of Your income while You are disabled. The amount You receive is based on the amount You earned before Your disability began, subject to all policy provisions.

**NAME OF EMPLOYER:**

**POLICY NUMBER:** [xxxxx]

**ELIGIBLE CLASS(ES):**

[All Employees] in Active Employment in the United States with the Employer.

You must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

[All persons who meet the membership eligibility criteria of the Policyholder].

[All persons in Active Employment [in the United States] with the Employer.]

[Persons who are not legal residents or citizens of the United States are not eligible for coverage.]

**MINIMUM HOURS REQUIREMENT:**

[30 hours per week]

**WAITING PERIOD:**

[As noted in Your Employer's Group Long Term Disability Insurance Policy]

**[REHIRE:**

If Your employment ends and You are rehired within [6] [12] months, Your previous work while in an eligible class will apply toward the Waiting Period. All other policy provisions apply.]

**[WAIVE THE WAITING PERIOD:**

If You have been continuously employed by Your Employer for a period of time equal to Your Waiting Period, We will waive Your Waiting Period when You enter an eligible class.]

**[CREDIT PRIOR SERVICE:**

We will apply any prior period of work with Your Employer toward the Waiting Period to determine Your eligibility date.]

**WHO PAYS FOR THE COVERAGE:**

[Your Employer pays the cost of Your coverage.]

[You and Your Employer share the cost of Your coverage.]

[You pay the cost of Your coverage.]

**WAIVER OF PREMIUM:**

We do not require premium payments for Your coverage while You are receiving or are entitled to receive Long Term Disability payments under the policy.

**[ELIMINATION PERIOD:**

[[1 day – 365] consecutive days.]

[1 day-365] [consecutive days for disability due to Injury.]]

[1 day-365] [consecutive days for disability due to Sickness.]]

[The latest of:

1. [1 day-365] consecutive days for disability due to Injury;
2. [1 day-365] consecutive days for disability due to a Sickness; or

3. the date Your Salary Continuation or Accumulated Sick Leave [or short term disability] payments end, if applicable.]

The elimination period begins on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.]

#### **[ACCUMULATION OF ELIMINATION PERIOD:**

Elimination period: [30- 365] consecutive days.

Accumulation period: [60 -730] consecutive days.

The elimination period and the accumulation period begin on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.]

#### **MONTHLY BENEFIT:**

[[40% - 80%] of Monthly Earnings to a Maximum Benefit of [\$500 - \$30,000] per month.]

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

#### **[MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY:**

[\$1000 - \$6,000] per month]

#### **MONTHLY EARNINGS:**

**(Current income before taxes, including deferred compensation)**

["Monthly Earnings" means Your gross monthly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, renewal commissions, tips and tokens, shift differential, expense reimbursements, bonuses, overtime pay, any other extra compensation, or income received from sources other than Your Employer.

[Monthly Earnings will be averaged for the lesser of:

- a) the 12 full calendar months period of Your employment with Your Employer just prior to the date Your disability begins; or
- b) the period of actual employment with Your Employer]

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the Monthly Payment.]

#### **MAXIMUM PERIOD OF PAYMENT:**

##### **(Social Security Normal Retirement Age duration (SSNRA))**

[For a disability which begins before You reach age 60, the Maximum Period of Payment will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

<b><u>Year of Birth</u></b>	<b><u>*Social Security Normal Retirement Age</u></b>
Before 1938	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943-1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months

1959	66 years and 10 months
1960 and after	67 years

\* Age at which You are entitled to unreduced Social Security benefits based on the Social Security Amendments of 1983.

For a disability which starts on or after You reach age 60, the Maximum Period of Payment will be determined according to the following table:

<b><u>Your Age When Disability Begins</u></b>	<b><u>Maximum Period of Payment</u></b>
Less than age 60	To Social Security Normal Retirement Age (SSNRA)*
Age 60	60 months or to SSNRA*, whichever is greater
Age 61	48 months or to SSNRA*, whichever is greater
Age 62	42 months or to SSNRA*, whichever is greater
Age 63	36 months or to SSNRA*, whichever is greater
Age 64	30 months or to SSNRA*, whichever is greater
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

**(5 Year/Social Security Normal Retirement Age duration (SSNRA))**

<b><u>Your Age When Disability Begins</u></b>	<b><u>Maximum Period of Payment</u></b>
Less than age 61	60 months
Age 61	48 months or to Social Security Normal Retirement Age (SSNRA)*, whichever is greater, not to exceed 60 months
Age 62	42 months or to SSNRA*, whichever is greater
Age 63	36 months or to SSNRA*, whichever is greater
Age 64	30 months or to SSNRA*, whichever is greater
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

<b><u>Year of Birth</u></b>	<b><u>*Social Security Normal Retirement Age</u></b>
Before 1938	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943-1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months
1959	66 years and 10 months
1960 and after	67 years

\* Age at which You are entitled to unreduced Social Security benefits based on the Social Security Amendments of 1983.]

**(ADEA – 65 Reducing Benefit Duration (RBD))**

<b><u>Age When Disability Begins</u></b>	<b><u>Maximum Period of Payment</u></b>
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months

Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

**(ADEA II - 65/5/70)**

**[Age When Disability Begins**

Less than age 60  
Age 60 - 64  
Age 65 - 69  
Age 70 and over

**Maximum Period of Payment**

To age 65 but not less than 5 years  
5 years  
To age 70, but not less than 1 year  
1 year]

**(ADEA III - To Age 70)**

**[Age When Disability Begins**

Less than age 70  
Age 70 and over

**Maximum Period of Payment**

To age 70, but not less than 1 year  
1 year]

**(10 Years or To Age 70)**

**[Age When Disability Begins**

Less than age 60  
Age 60 - 69  
Age 70 and over

**Maximum Period of Payment**

10 years  
To age 70, but not less than 1 year  
1 year]

**(5 Years or To Age 70)**

**[Age When Disability Begins**

Less than age 65  
Age 65 - 69  
70 and over

**Maximum Period of Payment**

5 years  
To age 70, but not less than 1 year  
1 year]

**(3 Years or To Age 70)**

**[Age When Disability Begins**

Less than age 67  
Age 67 - 69  
Age 70 and over

**Maximum Period of Payment**

3 years  
To age 70, but not less than 1 year  
1 year]

**(2 Years or To Age 70)**

**[Age When Disability Begins**

Less than age 66  
Age 66 - 69  
Age 70 and over

**Maximum Period of Payment**

2 years  
To age 70, but not less than 1 year  
1 year]

**(5 Years RBD)**

**[Age When Disability Begins**

Less than age 61  
Age 61  
Age 62  
Age 63  
Age 64  
Age 65

**Maximum Period of Payment**

60 months  
48 months  
42 months  
36 months  
30 months  
24 months

Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

### **(3 Years RBD)**

<b><u>[Age When Disability Begins</u></b>	<b><u>Maximum Period of Payment</u></b>
Less than age 64	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

### **(2 Years RBD)**

<b><u>[Age When Disability Begins</u></b>	<b><u>Maximum Period of Payment</u></b>
Less than age 66	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

### **[REGULAR OCCUPATION PERIOD:**

[6, 12, 24, 60] Months]

### **[TOTAL BENEFIT CAP:**

If You are eligible to receive payments under the policy in addition to Your Monthly Payment, the total benefit payable to You on a monthly basis (including all benefits provided under the policy) will not exceed 100% of Your Monthly Earnings] [unless an excess amount is payable as a result of a Cost of Living Adjustment]. [However, if You are participating in a Vocational Rehabilitation Plan, the total benefit payable to You on a monthly basis (including all benefits provided under this policy) will not exceed [110%] of Your Monthly Earnings] [unless an excess amount is payable as a result of a Cost of Living Adjustment].]

**The above items are only highlights of the policy. For a full description of Your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading Your Certificate of Coverage.]**

## **DEFINITIONS**

**[ACCIDENT OR ACCIDENTAL** means a sudden, unexpected event that was not reasonably foreseeable.]

**[ACCREDITED INSTITUTION** means any university, college or trade school, which is accredited by a regional accrediting agency that is recognized by the United States Department of Education.]

**ACTIVE EMPLOYMENT** means You are working for Your Employer for earnings that are paid regularly and that You are performing the Material and Substantial Duties of Your Regular Occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the SCHEDULE OF BENEFITS.

To be in Active Employment, Your work site must be:

1. Your Employer's usual place of business; or
2. an alternative work site at the direction of Your Employer, including Your home; or
3. a location to which Your job requires You to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

**[ACTIVITIES OF DAILY LIVING (ADLs)** are:

1. BATHING – washing oneself by sponge bath; or in either a tub or shower, including the task of getting into and out of the tub or shower.
2. DRESSING – putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
3. TOILETING – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
4. TRANSFERRING – moving into and out of a bed, chair, or wheelchair.
5. MOBILITY – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment.
6. CONTINENCE – the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
7. EATING – feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table).]

**APPROPRIATE CARE** means that You:

1. regularly visit a Doctor as frequently as medically required according to standard medical practice to effectively treat and manage Your disabling condition(s); and
2. receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a Doctor whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
3. have the obligation to minimize Your disabling condition including having corrective treatment or minor surgery.

**[CHILD** means a natural, step, foster or adopted child under age 15 who lives with You and is primarily dependent on You for financial support.]

**[COBRA** means the Consolidated Omnibus Budget Reconciliation Act.]

**[COBRA MEDICAL COVERAGE** means the continuation of Medical Coverage under Your Employer's plan as provided for under the Consolidated Omnibus Budget Reconciliation Act (COBRA).]

**CONTEST** means that, if We determine You made a material misrepresentation in Your application for coverage under the policy, We assert in writing that such coverage was therefore never effective. The contest is effective on the date We mail the letter along with a refund of premium.

**[COGNITIVE IMPAIRMENT** means You have a deterioration or loss in intellectual capacity, resulting from Injury, Sickness, Alzheimer's disease, or similar forms of irreversible dementia and You need another person's active help or verbal guidance for Your own protection or for the protection of others. The deterioration or loss will be based on clinical evidence and/or clinical tests, according to generally accepted medical standards, that reliably measure Your impairment. Cognitive Impairments which begin prior to the effective date of Your coverage will not be covered.]

**DEDUCTIBLE SOURCES OF INCOME** means income from other sources as listed in the policy which You receive or are eligible to receive while You are disabled. This income will be subtracted from Your Gross Monthly Payment.

**[DISABILITY EARNINGS** means the earnings which You receive while You are disabled and working, plus the earnings You could receive if You were working to Your Maximum Capacity.]

**DOCTOR** means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or
4. a person who is a legally qualified medical practitioner according to the Laws and regulations of the governing jurisdiction.

We will not recognize You or Your family members, including but not limited to, spouse, domestic partner, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with You as a Doctor for a claim that You send to Us.

**[ELIGIBLE STUDENT** means Your unmarried dependent Child under the age of 25 who is attending an Accredited Institution beyond the 12<sup>th</sup> grade level on a full-time basis.]

**[ELIGIBLE SURVIVOR** means Your spouse, if living; otherwise, Your children under age 25.]

**[EMPLOYEE** means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.]

(Standard)

**[EMPLOYER** means the Policyholder and includes any division, subsidiary, or affiliated company named in the policy.]

(Alternative)

**[EMPLOYER** means the entity that has been approved by Us for coverage under the policy issued to the Policyholder. Approval by Us of an Employer's plan of coverage under the policy is as recorded and maintained in Our underwriting files(s) for the policy.]

**[ENROLL** means You have completed the process of applying for coverage under the policy.]

**[ENROLLMENT FORM** means the application You complete and submit to Us to apply for coverage under the policy.]

**[EVIDENCE OF INSURABILITY** means a statement of Your medical history that We will use to determine if You are approved for coverage. Evidence of Insurability will be provided at Your own expense.]

**[EVIDENCE OF INSURABILITY FORM** means the portion of the Enrollment Form that You complete and submit to Us that contains a statement of Your medical history.]

**[FAMILY MEMBER** means an individual who can be claimed as a dependent by You for federal income tax purposes.]

**[GAINFUL OCCUPATION** means an occupation that is or can be expected to provide You with an income within 12 months of Your return to work, that exceeds:

[50% - 80%] of Your Indexed Monthly Earnings, if You are working;  
[50% - 80%] of Your Indexed Monthly Earnings, if You are not working.]

**GRACE PERIOD** means the [31-60] day period following the premium due date during which premium payment may be made.

**GROSS MONTHLY PAYMENT** means Your benefit before any reduction for Deductible Sources of Income [and Disability Earnings.]

**HOSPITAL, HEALTH FACILITY OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing Your disability.

**[IMPAIRED AND IMPAIRMENT** means:

1. You are prevented or limited from performing the Material and Substantial Duties of Your Regular Occupation, and as a result,
2. You suffer an involuntary earnings loss of 20% or more of Your Monthly Earnings.

We will consider You prevented or limited from performing the Material and Substantial Duties of Your Regular Occupation if as a direct result of testing positive for an Infectious and Contagious Disease:

1. restrictions are placed on You by a licensing or privileging board, Law or regulation;
2. You lose Your license, certification or privileges; or
3. You submit proof in a form acceptable to Us that You have suffered an involuntary loss of patients or loss of work assignments which loss cannot be replaced through reasonable accommodation.]

**INDEXED MONTHLY EARNINGS** means Your Monthly Earnings adjusted on each anniversary of benefit payment by the lesser of [1%-10%] or the current annual percentage increase in the Consumer Price Index. Your Indexed Monthly Earnings may increase or remain the same, but will never decrease.

The Consumer Price Index CPI-U is published by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while You are disabled and working and in the determination of Gainful Occupation.

**[INFECTIOUS AND CONTAGIOUS DISEASE** means a disease:

1. that is classified by the Centers for Disease Control and Prevention (CDC), located in Atlanta, Georgia, or its successor, as infectious and contagious; and
2. that is reasonably considered to pose an immediate or potential life-threatening risk to others while You perform Your Regular Occupation.]

**INJURY** means a bodily Injury that is the direct result of an Accident and not related to any other cause. The Injury must occur, and disability resulting from the Injury must begin while You are covered under the policy. Injury that occurs before You are covered under the policy will be treated as a Sickness.

**INSURED** means any person covered under the policy.

**INSURED PERSON** means a person who is eligible for the coverage under this policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.

**LAW, PLAN, or ACT** means the original enactments of the law, plan, or act and all amendments.

**MATERIAL AND SUBSTANTIAL DUTIES** means duties that:

1. are normally required for the performance of Your Regular Occupation; and
2. cannot be reasonably omitted or modified, except that if You are required to work on average in excess of 40 hours per week, We will consider You able to perform that requirement if You have the capacity to work 40 hours per week.

**MAXIMUM BENEFIT** means the total monthly benefit amount for which You are insured under the policy subject to all policy provisions.

**(1, 2, 3, 4, 5 year Regular Occupation)**

**[MAXIMUM CAPACITY** means, based on Your restrictions and limitations:

1. during the Regular Occupation Period, the greatest extent of work You are able to do in Your Regular Occupation; and
2. beyond the Regular Occupation Period, the greatest extent of work You are able to do in any occupation for which You are reasonably fitted by education, training or experience.]

**(Regular Occupation throughout the Maximum Period of Payment)**

**[MAXIMUM CAPACITY** means, based on Your restrictions and limitations, the greatest extent of work You are able to do in Your Regular Occupation.]

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time We will make payments to You for any one period of disability.

**[MEDICAL COVERAGE** means insurance provided under Your Employer's group health or medical plan that pays for Your medical, hospital or surgical expenses.]

**[MENTAL ILLNESS** means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.]

**MONTHLY EARNINGS** means Your gross monthly income from Your Employer as stated in the SCHEDULE OF BENEFITS.

**MONTHLY PAYMENT** means Your benefit after any Deductible Sources of Income [and Disability Earnings] have been subtracted from Your Gross Monthly Payment.

**OCCUPATIONAL SICKNESS OR INJURY** means a Sickness or Injury that was caused by or aggravated by any employment for pay or profit.

**[PART- TIME BASIS** means the ability to work and earn from 20% through [75% - 80%] of Your Indexed Monthly Earnings. Ability is based on capacity and not market availability.]

**PAYABLE CLAIM** means a claim for which We are liable under the terms of the policy.

(Standard)

**[POLICYHOLDER** means the Employer to whom the policy is issued and who sponsored the coverage for its Employees.]

(Alternative)

**[POLICYHOLDER** means the entity to whom the policy is issued.]

**[PRE-EXISTING CONDITION** means any condition for which You have done [, or for which an ordinarily prudent person would ordinarily have done,] any of the following at any time during the [3-12] months just prior to Your effective date of coverage, whether or not that condition is diagnosed at all or is misdiagnosed:

1. received medical treatment or consultation;
2. taken or were prescribed drugs or medicine; or
3. received care or services, including diagnostic measures.]

**[PROGRESSIVE DISEASE** means a non-infectious disease or disorder of indefinite duration that causes You to gradually become disabled as the disease or disorder becomes more severe or the symptoms of the disease become more frequent and impair Your ability to perform Your Regular Occupation.]

**RECURRENT DISABILITY** means a disability which is:

1. caused by a worsening in Your condition; and
2. due to the same cause(s) as Your prior disability for which We made a Monthly Payment.

**REGULAR OCCUPATION** means the occupation You are routinely performing when Your disability begins. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

**[REGULAR OCCUPATION PERIOD** is the period of time shown in the SCHEDULE OF BENEFITS that begins after the elimination period.]

**RETIREMENT PLAN** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to Employees and are not funded entirely by Employee contributions. Retirement plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

**SALARY CONTINUATION** or **ACCUMULATED SICK LEAVE** means continued payments to You by Your Employer of all or part of Your Monthly Earnings, after You become disabled as defined by the policy. This continued payment must be part of an established plan maintained by Your Employer, and includes Salary Continuation, Accumulated Sick Leave or any similar Employer sponsored paid time off plan.

**SICKNESS** means illness, disease or physical condition. Disability resulting from the Sickness must begin while You are covered under the policy.

**[SPECIAL CONDITIONS** means:

1. musculoskeletal and connective tissue disorders of the neck, back and shoulders including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including herniated or ruptured discs not requiring surgery, as well as sprains and strains of joints and adjacent muscles, except:
  - a. scoliosis;
  - b. spinal fractures;
  - c. osteopathies;
  - d. traumatic spinal cord necrosis;
  - e. radiculopathies, documented by electromyogram;
  - f. spondylolisthesis, grade II or higher;
  - g. myelopathies and myelitis;
  - h. demyelinating diseases; or
  - i. spinal tumors, malignancy, or vascular malformations.
2. chronic fatigue syndrome;
3. environmental allergic illness including but not limited to sick building syndrome and multiple chemical sensitivity;
4. carpal tunnel syndrome not requiring surgery;
5. fibromyalgia; or
6. myofascial pain syndrome.

If You are disabled due to carpal tunnel syndrome or one or more herniated or ruptured disc(s) and the carpal tunnel syndrome or herniated or ruptured disc(s) require that a surgical procedure be performed by a Doctor, then the Maximum Period of Payment will be up to [12][24] months immediately following the most recent surgical procedure.]

**[STAND-BY HELP** means You must have hands-on (active) help from another person with all or most of the activity.]

**[[TEMPORARY LAYOFF or] LEAVE OF ABSENCE** means You are absent from Active Employment for a period of time that has been agreed to in advance in writing by Your Employer.

Your normal vacation time or any period of disability is not considered a [Temporary Layoff or] Leave of Absence.]

**[TERMINAL ILLNESS** means a diagnosed illness that, according to generally accepted medical standards, is expected to result in death within 12 months.]

**[TREATMENT FREE** means You have not received medical treatment, consultation, care or services including diagnostic measures, and You have not taken or been prescribed drugs or medicines for the Pre-Existing Condition.]

**[VOCATIONAL REHABILITATION PLAN** means a written plan that a vocational rehabilitation professional, designated by Us, prepares in accordance with the VOCATIONAL REHABILITATION SERVICES provision of the policy.]

**WAITING PERIOD** means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that You must be in Active Employment in an eligible class before You are eligible for coverage under the policy.

**WE, US, and OUR** means Kansas City Life Insurance Company.

**YOU and YOUR** means a person who is eligible for coverage under the policy.]

## **DEFINITIONS**

**ACTIVE EMPLOYMENT** means You are working for Your Employer for earnings that are paid regularly and that You are performing the Material and Substantial Duties of Your Regular Occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the SCHEDULE OF BENEFITS.

To be in Active Employment, Your work site must be:

1. Your Employer's usual place of business; or
2. an alternative work site at the direction of Your Employer, including Your home; or
3. a location to which Your job requires You to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

**APPROPRIATE CARE** means that You:

1. regularly visit a Doctor as frequently as medically required according to standard medical practice to effectively treat and manage Your disabling condition(s);
2. receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a Doctor whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
3. have the obligation to minimize Your disabling condition including having corrective treatment or minor surgery.

**CONTEST** means that, if We determine You made a material misrepresentation in Your application for coverage under the policy, We assert in writing that such coverage was therefore never effective. The contest is effective on the date We mail the letter along with a refund of premium.

**DOCTOR** means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or
4. a person who is a legally qualified medical practitioner according to the Laws and regulations of the governing jurisdiction.

We will not recognize You or Your family members, including but not limited to, spouse, domestic partner, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with You as a Doctor for a claim that You send to Us.

[**EMPLOYEE** means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.]

(Standard)

[**EMPLOYER** means the Policyholder and includes any division, subsidiary, or affiliated company named in the policy.]

(Alternative)

[**EMPLOYER** means the entity that has been approved by Us for coverage under the policy issued to the Policyholder. Approval by Us of an Employer's plan of coverage under the policy is as recorded and maintained in Our underwriting files(s) for the policy.]

[**ENROLL** means You have completed the process of applying for coverage under the policy.]

[**ENROLLMENT FORM** means the application You complete and submit to Us to apply for coverage under the policy.]

[**EVIDENCE OF INSURABILITY** means a statement of Your medical history that We will use to determine if You are approved for coverage. Evidence of Insurability will be provided at Your own expense.]

[**EVIDENCE OF INSURABILITY FORM** means the portion of the Enrollment Form that You complete and submit to Us that contains a statement of Your medical history.]

**GAINFUL OCCUPATION** means an occupation that is or can be expected to provide You with an income of at least [\$1,000] per month, within 12 months of Your return to work.

**GRACE PERIOD** means the [31] day period following the premium due date during which premium payment may be made.

**HOSPITAL, HEALTH FACILITY OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing Your disability.

**INJURY** means a bodily Injury that is the direct result of an accident and not related to any other cause. The injury must occur, and disability resulting from the injury must begin while You are covered under the policy. Injury that occurs before You are covered under the policy will be treated as a Sickness.

**INSURED** means any person covered under the policy.

**INSURED PERSON** means a person who is eligible for the coverage under this policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.

**LAW, PLAN, or ACT** means the original enactments of the law, plan, or act and all amendments.

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time We will make payments to You for any one period of disability.

**MONTHLY EARNINGS** means Your gross monthly income from Your Employer as stated in the SCHEDULE OF BENEFITS.

**MONTHLY PAYMENT** means the Monthly Benefit amount.

**OCCUPATIONAL SICKNESS OR INJURY** means a Sickness or Injury that was caused by or aggravated by any employment for pay or profit.

**PAYABLE CLAIM** means a claim for which We are liable under the terms of the policy.

(Standard)

**POLICYHOLDER** means the Employer to whom the policy is issued and who sponsored the coverage for its Employees.

(Alternative)

[**POLICYHOLDER** means the entity to whom the policy is issued.]

**PRE-EXISTING CONDITION** means any condition for which You have done [, or for which an ordinarily prudent person would ordinarily have done,] any of the following at any time during the [3–24] months just prior to Your effective date of coverage, whether or not that condition is diagnosed at all or is misdiagnosed:

1. received medical treatment or consultation;
2. taken or were prescribed drugs or medicine; or
3. received care or services, including diagnostic measures.

**RECURRENT DISABILITY** means a disability which is:

1. caused by a worsening in Your condition; and
2. due to the same cause(s) as Your prior disability for which We made a Monthly Payment.

**REGULAR OCCUPATION** means the occupation You are routinely performing when Your disability begins. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

**SICKNESS** means illness, disease or physical condition. Disability resulting from the Sickness must begin while You are covered under the policy.

**[[TEMPORARY LAYOFF or] LEAVE OF ABSENCE** means You are absent from Active Employment for a period of time that has been agreed to in advance in writing by Your Employer.

Your normal vacation time or any period of disability is not considered a [Temporary Layoff or] Leave of Absence.]

**[TREATMENT FREE** means You have not received medical treatment, consultation, care or services including diagnostic measures, and You have not taken or been prescribed drugs or medicines for the Pre-Existing Condition.]

**WAITING PERIOD** means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that You must be in Active Employment in an eligible class before You are eligible for coverage under the policy.

**WE, US, and OUR** means Kansas City Life Insurance Company.

**YOU and YOUR** means a person who is eligible for coverage under the policy.]

## **GENERAL PROVISIONS**

### **CERTIFICATE OF COVERAGE**

This Certificate of Coverage is a written statement prepared by Us and may include attachments. It tells You:

1. the coverage to which You may be entitled;
2. to whom We will make a payment; and
3. the limitations, exclusions and requirements that apply within the policy.

(Standard)

#### **[ELIGIBILITY DATE**

If You are working for Your Employer in an eligible class, the date You are eligible for coverage is the later of:

1. the policy effective date; or
2. the day after You complete Your Waiting Period.]

(Alternative)

#### **[ELIGIBILITY DATE**

You are eligible for insurance under the policy if:

1. You meet the eligibility criteria of the Policyholder and You are not confined at home, in a hospital, convalescent care facility, a nursing home or elsewhere when the insurance would otherwise become effective, and You can perform all the usual and customary duties or activities of an individual in good health and of the same age and gender; and
2. You are in an eligible class under the policy.]

#### **[WHEN COVERAGE BEGINS**

When Your Employer pays 100% of the cost of Your coverage under the policy, You will be covered at 12:01 a.m. Standard Time at Your Employer's address on the date You are eligible for coverage.

When You and Your Employer share the cost of Your coverage under the policy or when You pay 100% of the cost yourself, You will be covered at 12:01 a.m. Standard Time at the Policyholder's address on the latest of:

1. the date You are eligible for coverage, if You Enroll for insurance on or before that date;
2. the [first day of the month following the] date You Enroll for insurance, if You Enroll within [31-60] days after the date You become eligible for coverage; or
3. the [first day of the month following the] date We approve Your Enrollment Form, if Evidence of Insurability is required.

In order for Your coverage to begin, You must be in Active Employment. Your coverage is subject to payment of premium.]

### **CHANGES TO YOUR COVERAGE**

Once Your coverage begins, any increased or additional coverage will take effect immediately if You are in Active Employment [or if You are on a covered [Temporary Layoff or] [Leave of Absence]]. If You are not in Active Employment due to Injury or Sickness, any increased or additional coverage will begin on the date You return to Active Employment.

Any decrease in coverage will take effect immediately but will not affect a Payable Claim that occurs prior to the decrease.

#### **[WHEN EVIDENCE OF INSURABILITY IS REQUIRED**

Evidence of Insurability is required if:

1. You are a late applicant, which means You Enroll for coverage more than [31-60] days after the date You are eligible for coverage;
2. You voluntarily canceled Your coverage and are reapplying.

An Evidence of Insurability Form can be obtained from Your Employer.]

## **[IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS]**

If You are on a Leave of Absence, and if premium is paid, Your coverage may be continued beyond the date You are no longer in Active Employment, limited to the time periods described below.

If You are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 ("FMLA") or applicable state family and medical leave Law ("State FML"), and Your Employer's Human Resource Policy provides for continuation of disability coverage during a FMLA or State FML Leave of Absence, Your coverage will be continued until the end of the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state Law.

If You are on a Leave of Absence other than a FMLA or State FML Leave of Absence, and if premium is paid, Your coverage will be continued through [the end of the month that immediately follows the month] in which Your Leave of Absence begins.

If You are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state Law, Your coverage may be continued until the end of the later of:

1. the length of time the coverage may be continued under the Certificate of Coverage for a FMLA or State FML Leave of Absence; or
2. the length of time the coverage may be continued under the Certificate of Coverage for a Leave of Absence other than a FMLA or State FML Leave of Absence.

If Your Employer has approved more than one type of Leave of Absence for You during any one period that You are not in Active Employment, We will consider such leaves to be concurrent for the purpose of determining how long Your coverage may continue under the policy.

If Your coverage is not continued during a FMLA or State FML Leave of Absence, and You return to Active Employment immediately following the end of Your FMLA or State FML Leave of Absence, Your coverage will be reinstated. We will not apply a new Waiting Period, require Evidence of Insurability, or apply a new Pre-Existing Condition limitation.

If Your coverage is not continued during a Leave of Absence for active military service, and You return to Active Employment, Your coverage may be reinstated in accordance with USERRA and applicable state Law.

In no event will Your coverage under the policy be continued beyond the date Your coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.]

## **[IF YOU ARE NOT IN ACTIVE EMPLOYMENT DUE TO A TEMPORARY LAYOFF [OR LABOR STRIKE]**

If You are not in Active Employment due to a Temporary Layoff, and if premium is paid, You will be covered through the [end of the month that immediately follows the month] in which Your Temporary Layoff begins.

[If You are not in Active Employment due to a labor strike, and if premium is paid, You will be covered through [the end of the month that immediately follows the month] in which the labor strike begins.]]

## **WHEN YOUR COVERAGE ENDS**

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled;
2. the date You are no longer in an eligible class;
3. the date Your eligible class is no longer covered;
4. the end of the Grace Period after a premium due date, if premium is not paid; or
5. the last day You are in Active Employment [except as provided under a covered Leave of Absence [[or] [,] Temporary Layoff[,]] [or labor strike]].

We will provide coverage for a Payable Claim that occurs while You are covered under the policy.

## **[PORTABILITY]**

You may continue Your coverage for up to [12] [24] months if Your employment ends. However, to be eligible to continue coverage, You must meet the following requirements on the date Your employment ends:

1. You have been covered under the policy for at least [6] [12] consecutive months just prior to the date Your employment ends;
2. You are not unable to perform or not limited from performing the Material and Substantial Duties of Your Regular Occupation;
3. You are not on a Leave of Absence;
4. You are not age 65 or over;
5. You are not retired;
6. You are not covered under any other group disability plan; and
7. You are not absent due to a labor strike.

You must apply in writing and pay the first premium to Us within [31- 45] days after the date Your employment ends.

[The coverage continued is Your coverage in force on the date Your employment with the Employer ends. Your Pre-Disability Earnings will be based on Your earnings in effect on the date Your employment ended.]

[The coverage continued is [40%-50%] of Your Monthly Benefit level in force on the date Your employment with the Employer ended. Your Pre-Disability Earnings will be based on Your earnings in effect on the date Your employment ended. If benefits are payable under the policy, You will receive benefits for the lesser of 12 months or the Maximum Period of Payment of the policy, if You continue to be Disabled according to the terms of the policy.]

Insurance continued under this provision ends automatically on the earliest of:

1. the end of the Grace Period after a premium due date, if premium is not paid;
2. the date You become a full-time member of the armed forces of any country;
3. the date You retire;
4. the date You reach age 65;
5. the end of the [12] [24] months during which Your insurance is continued;
6. the date the group policy terminates;
7. the date You become covered under another group disability plan;
8. the date You were absent due to a labor strike[.]; or
9. the end of [3-12] months after the effective date of Portability during which Your insurance was continued and You are not employed.]

## **TIME LIMITS FOR LEGAL PROCEEDINGS**

You can start legal action regarding Your claim 60 days after proof of claim has been given to Us, and up to three years from the time proof of claim is required, unless otherwise provided under federal Law.

## **STATEMENTS MADE IN AN APPLICATION FOR COVERAGE**

We consider any statements the Policyholder [, Your Employer,] and You make in an application representations and not warranties. No statements made by You will be used to reduce or deny any claim or to cancel Your coverage unless:

1. the statement is in writing and is signed by You; and
2. a copy of that statement is given to You or Your beneficiary.

## **TIME LIMIT ON CERTAIN DEFENSES**

Except in the case of fraud, no statement made by You relating to Your insurability will be used to Contest the insurance for which the statement was made after the coverage has been in force for two years.

Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no claim for disability with respect to which the claim is made, shall be reduced or denied on the ground that a disease or physical condition, not excluded from

coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

### **CLERICAL ERROR**

Clerical error or omission by Us [or], the Policyholder [or Your Employer] will not:

1. prevent You from receiving coverage, if You are entitled to coverage under the terms of the policy; or
2. cause coverage to begin or continue for You when the coverage would not otherwise be effective.

If the Policyholder [or Your Employer] gives Us information about You that is incorrect, We will:

1. use the facts to decide whether You have coverage under the policy and in what amounts; and
2. make a fair adjustment of the premium.

### **MISSTATEMENT OF AGE**

If premiums applicable to You are based on age and You have misstated Your age, there will be a fair adjustment of premiums based on Your true age. If the benefits applicable to You are based on age and You have misstated Your age, there will be an adjustment of said benefits based on Your true age. We may require satisfactory proof of Your age before paying any claim.

### **WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE**

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

### **AGENCY**

For purposes of the policy, the Policyholder [and Your Employer] acts on [its][their] own behalf or as Your agent. Under no circumstances will the Policyholder [or Your Employer] be deemed Our agent.

## **[LONG TERM DISABILITY BENEFIT INFORMATION]**

### **DEFINITION OF DISABILITY**

#### **(Residual – 1, 2, 3, 4, 5 Years Regular Occupation with both loss of duties and earnings loss)**

[You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation; and
2. You have a 20% or more loss in Your Indexed Monthly Earnings.]

#### **(Residual – 1, 2, 3, 4, 5 Years Regular Occupation with either loss of duties or earnings loss)**

[You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation; or
2. Your Disability Earnings if any, are less than [75% - 80%] of Your Indexed Monthly Earnings.]

#### **(Used if Any Gainful Occupation Definition of Disability follows Regular Occupation Period)**

[After the Regular Occupation Period, You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience.]

#### **(Used if ADL Definition of Disability follows Regular Occupation Period)**

[After the Regular Occupation Period You will be considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience, and
2. a. You are continuously unable to perform two or more Activities of Daily Living (ADLs), without Stand-By Help; or  
b. You have a Cognitive Impairment; or  
c. You have a Terminal Illness.]

#### **(Used for Pilots Definition of Disability)**

[Throughout the Maximum Period of Payment, if You are employed as a pilot, co-pilot, or crew of an aircraft, You are disabled when We review Your claim and determine that, due to Your Sickness or Injury, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience.]

#### **(Partial –1, 2, 3, 4, 5 Years Regular Occupation with both loss of duties and earnings loss)**

[You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation;
2. You have a 20% or more loss in Your indexed Monthly Earnings; and
3. during the elimination period, You are unable to perform any of the Material and Substantial Duties of Your Regular Occupation, and You are not working in any occupation.]

#### **(Partial –1, 2, 3, 4, 5 Years Regular Occupation with either loss of duties or earnings loss)**

[You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation; or
2. Your Disability Earnings if any, are less than [75% - 80%] of Your Indexed Monthly Earnings; and
3. during the elimination period, You are unable to perform any of the Material and Substantial Duties of Your Regular Occupation, and You are not working in any occupation.]

#### **(Used if Any Gainful Occupation Definition of Disability follows Regular Occupation Period)**

[After the Regular Occupation period, You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience.]

#### **(Used if ADL Definition of Disability follows Regular Occupation Period)**

[After the Regular Occupation Period You will be considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience, and
2. a. You are continuously unable to perform two or more Activities of Daily Living (ADLs), without Stand-By Help; or  
b. You have a Cognitive Impairment; or  
c. You have a Terminal Illness.]

**(Used for Pilots Definition of Disability)**

[Throughout the Maximum Period of Payment, if You are employed as a pilot, co-pilot, or crew of an aircraft, You are disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience; and
2. during the elimination period, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience, and You are not working in any occupation.]

**(Residual - Regular Occupation, throughout the Maximum Period of Payment)**

[You are considered disabled when We review Your claim and determine that due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation; and
2. You have a 20% or more loss in Your indexed Monthly Earnings.]

**(Used for Pilots Definition of Disability)**

[Throughout the Maximum Period of Payment, if You are employed as a pilot, co-pilot, or crew of an aircraft, You are disabled when We review Your claim and determine that, due to Your Sickness or Injury, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience.]

**(Partial – Regular Occupation, throughout the Maximum Period of Payment)**

[You are considered disabled when We review Your claim and determine that due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial Duties of Your Regular Occupation;
2. You have a 20% or more loss in Your Indexed Monthly Earnings; and
3. during the elimination period, You are unable to perform any of the Material and Substantial Duties of Your Regular Occupation, and You are not working in any occupation.]

**(Used for Pilots Definition of Disability)**

[Throughout the Maximum Period of Payment, if You are employed as a pilot, co-pilot, or crew of an aircraft, You are disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience; and
2. during the elimination period, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience, and You are not working in any occupation.]

**(Total – Regular Occupation, throughout the Maximum Period of Payment)**

[You are considered disabled when We review Your claim and determine that due to Your Sickness or Injury, You are unable to perform the Material and Substantial Duties of Your Regular Occupation, and You are not working in any occupation.]

**(Used for Pilots Definition of Disability)**

[Throughout the Maximum Period of Payment, if You are employed as a pilot, co-pilot, or crew of an aircraft, You are disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience; and
2. during the elimination period, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience, and You are not working in any occupation.]

**(For all plans)**

The loss of a professional or an occupational license or certification does not, in itself, constitute disability.

You must be under the Appropriate Care of a Doctor in order to be considered disabled.

We may require You to be examined by one or more Doctors, other medical practitioners, or vocational experts of Our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require You to be interviewed by Our authorized representative. Your failure to comply with this request may result in denial or termination of benefits.

**[ELIMINATION PERIOD]**

You must be continuously disabled through Your elimination period. Your elimination period is as stated in the SCHEDULE OF BENEFITS and is the period of continuous disability You must satisfy before You are eligible to receive benefits under the policy.

[[For an elimination period more than 90 days, We will consider Your disability as continuous if Your disability stops during the elimination period for 30 days or less.]

[For an elimination period of 90 days, We will consider Your disability as continuous if Your disability stops during the elimination period for 14 days or less.]

[For an elimination period of 31 to 90 days, We will consider Your disability as continuous if Your disability stops during the elimination period for 7 days or less for each 30 days of elimination period.]

[If Your elimination period is less than 30 days, and Your disability stops during the elimination period, We will not consider Your disability to be continuous.]

[The days that You are not disabled will not count toward Your elimination period.]]

The elimination period begins on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.]

**[ACCUMULATION OF ELIMINATION PERIOD]**

You must be continuously disabled through Your elimination period. Your elimination period is as stated in the SCHEDULE OF BENEFITS and is the period of continuous disability You must satisfy before You are eligible to receive benefits under the policy.

If You return to work while satisfying Your elimination period, You may satisfy Your elimination period within the accumulation period. The accumulation period is as stated in the SCHEDULE OF BENEFITS.

The days that You are not disabled will not count toward Your elimination period.

If You do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

The elimination period and the accumulation period begin on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.]

**[SATISFYING YOUR ELIMINATION PERIOD IF YOU ARE WORKING]**

[If You are working while You are disabled, the days You are disabled will count toward Your elimination period.]

**WHEN YOU RECEIVE PAYMENTS**

You will begin to receive payments when We approve Your claim, providing the elimination period has been met and You are disabled. We will send You a Monthly Payment at the end of each month for any period for which We are liable.

After the elimination period, if You are disabled for less than 1 month, We will send You 1/30<sup>th</sup> of Your Monthly Payment for each day of Your disability.

**AMOUNT OF PAYMENT**

**[A. IF YOU ARE DISABLED AND NOT WORKING [, OR DISABLED AND WORKING AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR INDEXED MONTHLY EARNINGS]]**

**(Direct)**

[We will follow this process to figure Your payment:

1. Multiply Your Monthly Earnings by [40% - 80%].
2. The Maximum Benefit is [\$500 - \$30,000] per month.
3. Compare the answer from Item 1 with the Maximum Benefit. The lesser of these two amounts is Your Gross Monthly Payment.
4. Subtract from Your Gross Monthly Payment any Deductible Sources of Income.

The amount figured in Item 4 is Your Monthly Payment.]

**[(70% - 100%) All Sources]**

[We will follow this process to figure Your payment:

1. Multiply Your Monthly Earnings by [40% - 80%].
2. The Maximum Benefit is [\$500 - \$30,000] per month.
3. Compare the answer from Item 1 with the Maximum Benefit. The lesser of these two amounts is Your Gross Monthly Payment.
4. Multiply Your Monthly Earnings by [70% - 100%] and subtract any Deductible Sources of Income except income from any form of employment.
5. Compare the answer from Item 3 and Item 4.

The lesser amount figured in Item 5 is Your Monthly Payment.]

**(Regular Occupation with both loss of duties and earnings loss)**

**[B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO [75% - 80%] OF YOUR INDEXED MONTHLY EARNINGS]**

**(Regular Occupation with either loss of duties or earnings loss)**

**[B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% OF YOUR INDEXED MONTHLY EARNINGS]**

**(DIRECT – with Work Incentive Period – thereafter, Proportionate Loss or 50% offset)**

[During the first [12] [24] months of payments, the][The] sum of Your Gross Monthly Payment plus Disability Earnings may be less than or equal to, but not more than, 100% of Your Indexed Monthly Earnings. If the sum exceeds 100% of Your Indexed Monthly Earnings, We will reduce Your payment under the policy by the excess amount.

To determine whether the sum of Your Gross Monthly Payment plus Disability Earnings is less than or equal to or exceeds 100% of Your Indexed Monthly Earnings, We will follow this process:

[

1. Multiply Your Monthly Earnings by [40% - 80%].
2. The Maximum Benefit is [\$500 - \$30,000] per month.
3. Compare the answer from Item 1 with the Maximum Benefit. The lesser of these two amounts is Your Gross Monthly Payment.
4. Add Your Disability Earnings to Your Gross Monthly Payment.]

If the answer [in Item 4 above] is less than or equal to 100% of Your Indexed Monthly Earnings, Your Monthly Payment will be Your Gross Monthly Payment minus any Deductible Sources of Income.

If the answer in Item 4 above is greater than 100% of Your Indexed Monthly Earnings, We will follow this process to figure Your Monthly Payment:

- a. Add Your Disability Earnings to Your Gross Monthly Payment.
- b. From the answer in Item a, subtract Your Indexed Monthly Earnings. If the result is zero or less, record Your answer as zero.
- c. From Your Gross Monthly Payment, subtract the answer in Item b and any Deductible Sources of Income.

The amount figured in Item c is Your Monthly Payment.]

**(Followed by either proportionate loss or 50% offset formula)**

**(Proportionate loss formula)**

[After [12] [24] months of Monthly Payments, You will receive payments based on the percentage of income You are losing due to Your Disability. We will follow this process to determine Your Monthly Payment:

1. Subtract Your Disability Earnings from Your Indexed Monthly Earnings.
2. Divide the answer in Item 1 by Your Indexed Monthly Earnings. The result is Your percentage of lost earnings.
3. From Your Gross Monthly Payment, subtract any Deductible Sources of Income.
4. Multiply the answer in Item 2 by the answer in Item 3.]

The answer in Item 4 is Your Monthly Payment.]

**(50% offset formula)**

[After [12] [24] months of payments, Your Monthly Payment will be reduced by 50% of Your Disability Earnings. We will follow this process to determine Your Monthly Payment:

1. Multiply Your Disability Earnings by 50%.
2. From Your Gross Monthly Payment, subtract the answer in Item 1 and any Deductible Sources of Income.

The answer in Item 2 is Your Monthly Payment.]

**[C. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN [75% - 80%] OF YOUR INDEXED MONTHLY EARNINGS**

If You are working and Your Disability Earnings are more than [75% - 80%] of Your Indexed Monthly Earnings, no benefit will be payable.]

**(For all plans)**

[We may require You to send proof of Your monthly Disability Earnings [at least quarterly][each month]. We will adjust Your payment based on Your monthly Disability Earnings.

As part of Your proof of Disability Earnings, We can require that You send Us appropriate financial records that We believe are necessary to substantiate Your income.]

After the elimination period, if You are disabled for less than 1 month, We will send You 1/30<sup>th</sup> of Your Monthly Payment for each day of disability.

**[IF YOUR DISABILITY EARNINGS FLUCTUATE**

If Your Disability Earnings routinely fluctuate widely from month to month, We may average Your Disability Earnings over the most recent three months to determine if Your claim should continue.

If We average Your Disability Earnings, We will not terminate Your claim unless the average of Your Disability Earnings from the last three months exceeds [75% - 80%] of Your Indexed Monthly Earnings.

We will not pay You for any month during which Your Disability Earnings exceed the amount allowable under the policy. In no event will benefits be paid beyond the Maximum Period of Payment.]

**WE WILL NEVER PAY MORE THAN 100% OF MONTHLY EARNINGS**

If You are eligible to receive benefits under the policy in addition to the Monthly Payment, the total benefit payable to You on a monthly basis (including all benefits provided under the policy) will not exceed 100% of Your Monthly Earnings] [unless an excess amount is payable as a result of a Cost of Living Adjustment]. [However, if You are participating in a Vocational Rehabilitation Plan, the total benefit payable to You on a monthly basis (including all benefits provided under this policy) will not exceed [110% - 125%] of Your Monthly Earnings] [unless an excess amount is payable as a result of a Cost of Living Adjustment].

**[COST OF LIVING ADJUSTMENT**

We will make a Cost of Living Adjustment (COLA) after You have received [one full year of Monthly Payments].

Your payment will increase by [.5% - 10%] of Your Gross Monthly Payment beginning on the first anniversary of payments and each following anniversary [not to exceed [5] [10] anniversary adjustment periods] while You continue to receive payments for Your disability.

Each month, We will add the Cost of Living Adjustment to Your Monthly Payment. When We add the adjustment to Your payment, the increase may cause Your payment to exceed the Maximum Benefit.

[Compounding will continue up to the maximum number of adjustments.]]

## **DEDUCTIBLE SOURCES OF INCOME**

The following are Deductible Sources of Income:

1. The amount that You receive, or are eligible to receive, as disability income payments under any:
  - a. state compulsory benefit Act or Law;
  - b. [individual disability income plans which are paid for by the Policyholder and purchased on or after the effective date of this policy;]
  - c. automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable;
  - d. military disability benefit plan;
  - e. governmental retirement system as a result of Your job with Your Employer; or
  - f. other group insurance policy.
2. The amount You receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
3. The amount You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, [not to exceed 50% of the net settlement].
- [4. The amount You receive under any Salary Continuation or Accumulated Sick Leave plan.]
5. The amount that You:
  - a. receive as disability payments under Your Employer's Retirement Plan;
  - b. voluntarily elect to receive as retirement payments under Your Employer's Retirement Plan; or
  - c. are eligible to receive as retirement payments when You reach the later of age 62 or normal retirement age, as defined in Your Employer's Retirement Plan.

Disability payments under a Retirement Plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are paid based on Your Employer's contribution to the Retirement Plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the Retirement Plan are distributed, We will consider the Employer and Employee contributions to be distributed simultaneously throughout Your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible Retirement Plan. We will use the definition of eligible Retirement Plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

### (For Primary & Family Integration)

- [6. The amount that You, Your spouse, and Your children receive, or are eligible to receive, as disability payments because of Your disability under:
  - a. the United States Social Security Act;
  - b. the Canada Pension Plan;
  - c. the Quebec Pension Plan; or

d. any similar Plan or Act.

7. The amount that You receive as retirement payments or the amount Your spouse and Your children receive as retirement payments because You are receiving retirement payments under:

- a. the United States Social Security Act;
- b. the Canada Pension Plan;
- c. the Quebec Pension Plan; or
- d. any similar Plan or Act.]

(For Primary Integration only)

[6. The amount that You receive or are eligible to receive as disability payments under:

- a. the United States Social Security Act;
- b. the Canada Pension Plan;
- c. the Quebec Pension Plan; or
- d. any similar Plan or Act.

We will not offset with any amount received by Your spouse or dependents.]

7. The amount that You receive as retirement payments under:

- a. the United States Social Security Act;
- b. the Canada Pension Plan;
- c. the Quebec Pension Plan; or
- d. any similar Plan or Act.

We will not offset with any amount received by Your spouse or dependents.]

8. The amount You earn or receive from any form of employment.

[9. The amount You receive from any unemployment compensation Law.]

[10. The amount that You receive, or are eligible to receive, under:

- a. a workers' compensation Law;
- b. an occupational disease Law; or
- c. any other Act or Law with similar intent.]

With the exception of retirement payments, We will only subtract Deductible Sources of Income which are payable as a result of the same disability.

We will not reduce Your payment by Your Social Security retirement income if Your disability begins after age 65 and You were already receiving Social Security retirement payments.

[If You begin to receive or are eligible to receive a Social Security payment while You are eligible to receive payments under this policy, We will not reduce Your Monthly Benefit under this policy by the amount of the first monthly Social Security payment You receive or are eligible to receive. Thereafter, Your Monthly Benefit under this policy will be reduced by any monthly Social Security payments You receive or are eligible to receive.]

#### **IF YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME**

Other than for increases in any income You earn from any form of employment, once We have subtracted any Deductible Source of Income from Your Gross Monthly Payment, We will not further reduce Your payment due to a cost of living increase from that source.

## **IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME**

When We determine that You may qualify for benefits for which You are eligible in the Deductible Sources of Income section, We will estimate Your entitlement to these benefits. We can reduce Your benefit under the policy by the estimated amounts if such benefits:

1. have not been awarded or denied; or
2. have been denied and the denial is being appealed.

Your Gross Monthly Payment will NOT be reduced by the estimated amount if You:

1. apply for the disability payments for which You are eligible in the Deductible Sources of Income section and appeal Your denial to all administrative levels We determine are necessary; and
2. sign Our form. This form states that You promise to pay Us any overpayment caused by an award and We shall be entitled to impose a constructive trust on any such award.

If Your Gross Monthly Payment has been reduced by an estimated amount, Your Gross Monthly Payment will be adjusted when We receive proof:

1. of the amount awarded; or
2. that benefits have been denied and all appeals We determine are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to You.

If You receive a lump sum payment from any Deductible Source of Income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis from the date of the award over Your expected lifetime as determined by Us.

## **NON-DEDUCTIBLE SOURCES OF INCOME**

We will not subtract from Your Gross Monthly Payment income You receive from, the following:

1. 401(k) plans;
2. [Salary Continuation or Accumulated Sick Leave plans;]
3. profit sharing plans;
4. thrift plans;
5. tax-sheltered annuities;
6. stock ownership plans;
7. credit disability insurance;
8. non-qualified plans of deferred compensation;
9. pension plans for partners;
10. military pension plans;
11. franchise disability income plans;
12. individual disability plans paid for by the Insured Person;
13. a retirement plan from another employer;
14. individual retirement accounts (IRA).

[If Salary Continuation or Accumulated Sick Leave plan payments plus the Gross Monthly Payment and Disability Earnings exceed 100% of Your Monthly Earnings, We will subtract the amount in excess of 100% from Your Monthly Payment.]

## **MINIMUM PAYMENT**

The minimum payment each month for a Payable Claim is [the greater of:

1. ][\$100] [\$50][.]; or
2. [5%-30%] of Your Gross Monthly Payment.]

We may apply this amount to recover an outstanding overpayment.

## **DURATION OF PAYMENTS**

We will send You a payment each month up to the Maximum Period of Payment. Your Maximum Period of Payment is stated in the SCHEDULE OF BENEFITS will be paid during a continuous period of disability, and will be based on Your age at disability.

## **WHEN PAYMENTS END**

### **(1, 2, 3, 4, 5 Year Regular Occupation with both loss of duties and earnings loss)**

[We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer disabled under the terms of the policy;
3. the date You fail to submit proof of continuing disability;
4. the date You die;
5. during the Regular Occupation Period when You are able to return to work in Your Regular Occupation on a Part-Time Basis but You do not;
6. after the Regular Occupation Period, when You are able to work in any Gainful Occupation on a Part-Time Basis but You do not;[or]
7. [the date Your Disability Earnings exceed [75% - 80%] of Your Indexed Monthly Earnings.] [;][or]]
8. after 12 months of payments if You are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when You have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.]

We will not pay a benefit for any period of disability during which You are incarcerated.]

### **(Regular Occupation throughout the Maximum Period of Payment – Partial or Residual)**

[We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer disabled under the terms of the policy;
3. the date You fail to submit proof of continuing disability;
4. the date You die;
5. when You are able to return to work in Your Regular Occupation on a Part-Time basis but You do not; [or]
6. [the date Your Disability Earnings exceed [75% - 80%] of Your Indexed Monthly Earnings.] [; ][or]]
7. after 12 months of payments if You are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when You have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.]

We will not pay a benefit for any period of disability during which You are incarcerated.]

### **(Total – Regular Occupation, throughout the Maximum Period of Payment OR Partial or Residual with either loss of duties or earnings loss)**

[We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer disabled under the terms of the policy;
3. the date You fail to submit proof of continuing disability; [or]
4. the date You die[.] [;or]
5. after 12 months of payments if You are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when You have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.]

We will not pay a benefit for any period of disability during which You are incarcerated.]

## **DISABILITIES NOT COVERED UNDER THE POLICY**

The policy does not cover any disabilities caused by, contributed to by, or resulting from Your:

1. loss of professional license, occupational license, or certification;
2. participation in a felony;
3. intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;[

5. being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor;]
6. participation in a war, declared or undeclared, or any act of war;
7. active military duty;
8. active participation in a riot;
9. engaging in any illegal or fraudulent occupation, work, or employment;
10. commission of a crime for which You have been convicted;
11. elective surgery except when required for Your Appropriate Care as a result of Your Injury or Sickness; [or]
12. traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes[.];[or]
13. Occupational Sickness or Injury.]

#### **[PRE-EXISTING CONDITION LIMITATION**

[Benefits will not be paid if Your disability begins in the first [12-24] months following the effective date of Your coverage and Your disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which[:

1. ]You received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the [3-12] months just prior to Your effective date of coverage[.]; or
2. You had symptoms for which an ordinarily prudent person would have consulted a Doctor in the [3-12] months just prior to Your effective date of coverage.]]

[Benefits will not be paid if Your disability begins in the first [12-24] months following the effective date of Your coverage and Your disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the [3-12] months just prior to Your effective date of coverage [; or
2. You had symptoms for which an ordinarily prudent person would have consulted a Doctor in the [3-12] months just prior to Your effective date of coverage]; and
3. You were not Treatment Free for [6-12] consecutive months after Your effective date of coverage].

[If there is an increase in the Maximum Benefit after the Policy Effective Date, this PRE-EXISTING CONDITION LIMITATION provision will apply to the amount of the increase in the Maximum Benefit, as of the effective date of the increase.]

#### **[MENTAL ILLNESS LIMITATION**

The [lifetime cumulative] Maximum Period of Payment for all disabilities due to Mental Illness is [12][24] months. Only [12][24] months of benefits will be paid even if the disabilities:

1. are not continuous; and/or
2. are not related.

We will continue to send You payments beyond the [12][24] month period if You meet one or both of these conditions:

1. If You are confined to a Hospital, Health Facility or Institution at the end of the [12][24] month period, We will continue to send You payment(s) during Your confinement.

If You are still disabled when You are discharged, We will send You payment(s) for a recovery period of up to 90 days.

If You become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, We will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if You continue to be disabled after the [12][24] month period, and subsequently become confined to a Hospital, Health Facility or Institution for at least 14 days in a row, We will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the Maximum Period of Payment, whichever occurs first.

We will not apply the Mental Illness limitation to a disability due to dementia if it is a result of:

1. stroke;
2. trauma;
3. viral infection; or
4. Alzheimer's disease.]

#### **[ALCOHOLISM OR DRUG ABUSE LIMITATION**

The [lifetime cumulative] Maximum Period of Payment for all disabilities due to alcoholism or drug abuse is [12][24] months. Only [12][24] months of benefits will be paid even if the disabilities:

1. are not continuous; and/or
2. are not related.

We will continue to send You payments beyond the [12][24] month period if You meet one or both of these conditions:

1. If You are confined to a Hospital, Health Facility or Institution at the end of the [12][24] month period, We will continue to send You payment(s) during Your confinement.

If You are still disabled when You are discharged, We will send You payment(s) for a recovery period of up to 90 days.

If You become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, We will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if You continue to be disabled after the [12][24] month period, and subsequently become confined to a Hospital, Health Facility or Institution for at least 14 days in a row, We will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the Maximum Period of Payment, whichever occurs first.]

#### **[MENTAL ILLNESS, ALCOHOLISM OR DRUG ABUSE LIMITATION**

The [lifetime cumulative] Maximum Period of Payment for all disabilities due to Mental Illness, alcoholism or drug abuse is [12][24] months. Only [12][24] months of benefits will be paid [for any combination of such disabilities] even if the disabilities:

1. are not continuous; and/or
2. are not related.

We will continue to send You payments beyond the [12][24] month period if You meet one or both of these conditions:

1. If You are confined to a Hospital, Health Facility or Institution at the end of the [12][24] month period, We will continue to send You payment(s) during Your confinement.

If You are still disabled when You are discharged, We will send You payment(s) for a recovery period of up to 90 days.

If You become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, We will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if You continue to be disabled after the [12][24] month period, and subsequently become confined to a Hospital, Health Facility or Institution for at least 14 days in a row, We will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the Maximum Period of Payment, whichever occurs first.

We will not apply the Mental Illness limitation to a disability due to dementia if it is a result of:

1. stroke;

2. trauma;
3. viral infection; or
4. Alzheimer's disease.]

### **[SPECIAL CONDITIONS LIMITATION**

The [lifetime cumulative] Maximum Period of Payment for all disabilities due to Special Conditions is [12][24] months. Only [12][24] months of benefits will be paid [for any combination of such disabilities] even if the disabilities:

1. are not continuous; and/or
2. are not related.

We will continue to send You payments beyond the [12][24] month period if You meet one or both of these conditions:

1. If You are confined to a Hospital, Health Facility or Institution at the end of the [12][24] month period, We will continue to send You payment(s) during Your confinement.

If You are still disabled when You are discharged, We will send You payment(s) for a recovery period of up to 90 days.

If You become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, We will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if You continue to be disabled after the [12][24] month period, and subsequently become confined to a Hospital, Health Facility or Institution for at least 14 days in a row, We will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the Maximum Period of Payment, whichever occurs first.]

### **RECURRENT DISABILITY**

If You have a Recurrent Disability, and after Your prior disability ended, You returned to work for Your Employer for 6 months or less, We will treat Your disability as part of Your prior claim and You do not have to complete another elimination period.

Your Monthly Payment will be based on Your Monthly Earnings as of the date of Your initial claim.

Your disability, as outlined above, will be subject to the same terms of this policy as Your prior claim.

Your disability will be treated as a new claim if Your current disability:

1. is unrelated to Your prior disability; or
2. after Your prior disability ended, You returned to work for Your Employer for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and You will be required to satisfy a new elimination period.

If Our policy terminates and You become eligible for payments under any other group disability plan that replaces Our policy, You will not be eligible for payments under Our policy.

### **BENEFITS IF YOU DIE - SURVIVOR BENEFIT**

(Only one option may be selected: 3 or 6 month OR 12 or 24 month Survivor Benefit)

(3 or 6 Month Survivor Option)

[When We receive proof that You have died, We will pay Your Eligible Survivor a lump sum benefit equal to [three (3)] [six (6)] times Your [last] [Gross] Monthly Payment if, on the date of Your death:

1. Your disability had continued for [30 - 180] or more consecutive days; and
2. You were receiving or were eligible to receive payments under the policy.

If You have no Eligible Survivors, payment will be made to Your estate, unless there is none. In this case, no payment will be made.

However, We will first apply the Survivor Benefit to recover any overpayment that may exist on Your claim.]

(12 or 24 Months Survivor Option)

[When We receive proof that You have died, We will pay Your Eligible Survivor a benefit equal to [40% - 80%] of Your [last] [Gross] Monthly Payment for [12] [24] months if, on the date of Your death:

1. Your disability had continued for 12 or more consecutive months; and
2. You were receiving payments under the policy.

If You have no Eligible Survivors, payment will be made to Your estate, unless there is none. In this case, no payment will be made.

However, We will first apply the Survivor Benefit to recover any overpayments that may exist on Your claim.]

**[ADVANCED SURVIVOR BENEFIT**

(3 or 6 Month Advanced Survivor Option)

You may receive an Advanced Survivor Benefit prior to Your death if You have been diagnosed with a Terminal Illness.

We will pay You a lump sum amount equal to [3] [6] times Your [last] [Gross] Monthly Payment if:

1. Your disability had continued for [ 30 - 180] or more consecutive days, and
2. You have been diagnosed with a Terminal Illness.

However, We will first apply the Advanced Survivor Benefit to recover any overpayment which may exist on Your claim.

Your right to exercise this option and receive payment is subject to the following:

1. You must make this election in writing to Us; and
2. Your Doctor must certify in writing that You have a Terminal Illness.

This benefit is available to You on a voluntary basis and will be payable one time only under this policy.

If You receive the Advanced Survivor Benefit prior to Your death, the [3] [6] month Survivor Benefit will not be payable upon Your death.]

**[ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT**

If an Accidental Injury:

1. occurs while You are insured under the policy; and
2. results in any of the losses shown in the schedule below within [180 - 360 ] days after the date of the Injury, then We will pay a Gross Monthly Payment to You for the longer of:
  - a. the number of payments listed on the schedule below; or
  - b. the number of months You remain disabled, not to exceed the Maximum Period of Payment.

Payment of this benefit will not be subject to satisfying the elimination period. However, after the elimination period has been completed, this benefit will be paid in lieu of the regular Monthly Payment, not in addition to it. If You remain disabled beyond the number of Monthly Payments under this provision, benefits may continue as provided under the policy. The months You receive benefits under this provision will be excluded in computing the number of months You receive payments for disability and in computing any remaining Maximum Period of Payment for disability. If You die, this benefit will cease.]

Monthly Payments for loss of:	Schedule of Monthly Payments

Sight of both eyes	46
Both hands	46
Both feet	46
One hand and one foot	46
One hand and sight of one eye	46
One foot and sight of one eye	46
One hand or one foot	23
Sight of one eye	15
Thumb and Index Finger of either hand	12

NOTE: The maximum number of Monthly Payments for all losses suffered from any one Accidental Injury shall be limited to that one loss for which the greatest number of Monthly Payments is provided in the above schedule.

"Loss of hands and feet" means the loss by severance at or above the wrist or ankle joint.

"Loss of sight" means total and irrecoverable loss of sight.

"Loss of thumb and index finger" means actual severance at or above the knuckles joining each to the hand.]

### **[EDUCATION EXPENSE BENEFIT**

If You are disabled and receiving Monthly Payments under this policy, You will receive a monthly Education Expense Benefit in the amount of [\$200 - \$1000] for each Eligible Student, limited to a combined monthly maximum of \$1,000. The Education Expense Benefit is in addition to Your Monthly Payment.

Benefits will be payable in between school terms as long as Your Eligible Student is enrolled for the next scheduled school term.

The Education Expense Benefit will end on the earlier of:

1. the date Your Child is no longer an Eligible Student; or
2. any other date the Monthly Payments would stop in accordance with the policy provisions.]

### **[EXTENDED EARNINGS PROTECTION BENEFIT**

We will send You a Monthly Payment if You have been disabled and You satisfy each of the following:

1. You have satisfied the elimination period for that disability; and
2. You return to Your Regular Occupation or another occupation full-time with the Employer [or another employer] the day after Your disability ends; and
3. You have a 20% or more loss in Your Indexed Monthly Earnings due to the same disability[.] ; and
4. You have received at least [3-24] Monthly Payments for that disability.]

The Extended Earnings Protection Benefit will be based on the percentage of income You have lost following Your return to work and will be calculated as follows:

1. Subtract Your current Monthly Earnings from Your Indexed Monthly Earnings.
2. Divide the answer in Item 1 by Your Indexed Monthly Earnings. The result is Your percentage of lost earnings.
3. Multiply the answer in Item 2 by Your Gross Monthly Payment.

The answer in Item 3 is Your Extended Earnings Protection Benefit.

The Extended Earnings Protection Benefit payment will end on the earlier of the following:

1. the date the Extended Earnings Protection Benefit has been paid for [3-24] months; or
2. the date Your current Monthly Earnings exceed [75%-80%] of Your Indexed Monthly Earnings.]

### **[PROGRESSIVE DISEASE BENEFIT**

Once You become insured under this policy and if You are diagnosed with a Progressive Disease, You will be eligible for the Progressive Disease Benefit.

To be eligible for this benefit You must provide Us with proof that You have been diagnosed with a Progressive Disease.

If You become disabled from a Progressive Disease and become eligible for benefits under this policy, the Monthly Earnings used to determine Your Monthly Payment will be the greater of:

1. Your Monthly Earnings at the time You provided Us with satisfactory proof of Your Progressive Disease; or
2. Your Monthly Earnings at the time You become disabled under this policy.

The premium for Your coverage under the policy will be based on the Monthly Earnings used to determine Your Monthly Payment, unless You qualify for waiver of premium under the terms of this policy.]

#### **[RETIREMENT CONTRIBUTION BENEFIT**

If You are disabled and qualify for a Monthly Payment from Us and have participated in Your Employer's [401(k), 403(b), 457, pension] plan for at least 3 months before You became Disabled, then You may be eligible to receive an additional benefit.

This additional benefit will equal the amount You were contributing toward Your Employer's [401(k) 403(b), 457, pension] plan as of the date of Your disability, but will not be more than [1% - 15%] of Your Monthly Earnings, and will not exceed the maximum allowable by Law.

If You are Disabled and working and earning between 20% through [75% - 80%] of Your Monthly Earnings, the benefit will be based on the percentage of income You are losing due to Your disability according to the following steps:

1. Subtract Your Disability Earnings from Your Monthly Earnings.
2. Divide the answer in Step 1 by Your Monthly Earnings. This is Your percentage of lost earnings.
3. Multiply Your additional benefit by the percentage of lost earnings determined in Step 2.

We will pay this additional benefit to the Employer for deposit into Your Employer's [401(k) 403(b), 457, pension] plan on Your behalf. If Your Employer's [401(k), 403(b), 457, pension] plan cannot accept the additional benefit, You may have an alternative retirement savings plan, such as a flexible premium deferred annuity, established and maintained by You to receive the additional benefit.

We will stop paying this benefit on the earliest of:

1. the date You are no longer disabled under the terms of this policy;
2. the date You stop participating in the Employer's [401(k), 403(b), 457, pension] plan;
3. the date You do not have a retirement savings plan in effect that can accept the additional benefit; or
4. the date You stop receiving disability payments from Us under this policy.]

#### **[SUPPLEMENTAL DISABILITY BENEFIT**

We will pay You an additional supplemental disability benefit equal to [10% - 40%] of Your Monthly Earnings, not to exceed [\$1,000 - \$5000] per month, if You are unable to perform the Material and Substantial Duties of Your Regular Occupation due to Your Sickness or Injury, and You:

1. are continuously not able to perform two or more Activities of Daily Living (ADL), without Stand-By Help; or
2. have a Cognitive Impairment; or
3. have a Terminal Illness.]

#### **[IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY (Continuity of Coverage)**

If You are not in Active Employment due to Injury[,][or] Sickness [,or] [Leave of Absence] [or Temporary Layoff] on the date Your Employer changes insurance carriers to Our policy, and You were covered under the prior policy at the time Your Employer's coverage under Our policy became effective, We will provide continuity of coverage under Our policy. In order for this provision to apply, the prior policy's coverage must be similar to Our policy.

If You are not in Active Employment due to Injury[,][or] Sickness [,or] [Leave of Absence] [or Temporary Layoff] on the effective date of Our policy, and You would otherwise be eligible to become insured under Our policy, We will provide limited coverage under Our policy. Coverage under this provision will begin on Our policy effective date and will continue until the earliest of:

1. the [end of the month following the] date You return to Active Employment; or
2. the end of any period of continuance or extension provided under the prior policy; or
3. the date coverage would otherwise end, according to the provisions of Our policy.

Your coverage under this provision is subject to payment of premium.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. We will reduce Your payment by any amount for which the prior carrier is liable.

If coverage ends under this provision, or if You were not covered under Your Employer's prior policy on the date that policy terminated, the WHEN COVERAGE BEGINS provision under Our policy will apply.]

**[IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY (Continuity of Coverage)]**

We may send a payment if Your disability is caused by, contributed by or results from a Pre-Existing Condition if:

1. You were insured by the prior policy at the time Your Employer changed insurance carriers to Our policy; and
2. You have been continuously covered under Our policy from the effective date of Your Employer's policy through the date Your disability began.

In order to receive a payment, You must satisfy the Pre-Existing Condition provision under:

1. Our policy; or
2. the prior policy, if benefits would have been paid had that policy remained in force.

If You satisfy the Pre-Existing Condition provision of Our policy, We will determine Your payments according to Our policy's provisions.

If You do not satisfy the Pre-Existing Condition provision of this policy, but You do satisfy the prior policy's Pre-Existing Condition provision:

1. Your Monthly Payment will be the lesser of:
  - a. the Monthly Payment that would have been payable under the terms of the prior policy if it had remained in force;  
or
  - b. the Monthly Payment under Our policy; and
2. benefits will end on the earlier of:
  - a. the date benefits end under Our policy, as described under the DURATION OF PAYMENTS provision; or
  - b. the date benefits would have ended under the prior policy if it had remained in force.

If You do not satisfy either Our policy's or the prior policy's Pre-Existing Condition provision, We will not make any payments.

We will require proof that You were insured under the prior policy.

All other provisions of Our policy will apply.]

**[VOCATIONAL REHABILITATION SERVICES]**

We have vocational rehabilitation services available to assist You in returning to work to the extent of Your ability. We will review Your disability claim to determine whether You are eligible for these services, at Our sole discretion. In order to be eligible for vocational rehabilitation services [and benefits], You must be medically able to participate in a return to work plan.

Your claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services might help You return to gainful employment. As Your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work plan.

We will make the final determination of Your eligibility for these services.

If We determine that vocational rehabilitation services are appropriate, We will provide You with a written Vocational Rehabilitation Plan developed specifically for You.

The Vocational Rehabilitation Plan may include at Our sole discretion, but is not limited to, the following services:

1. coordination with Your Employer to assist You to return to work;
2. evaluation of adaptive equipment or job accommodations to allow You to work;

3. evaluation of possible workplace modifications which might allow You to return to work in Your Regular Occupation or another job or occupation;
4. vocational evaluation to determine how Your disability may impact Your employment options;
5. job placement services, including resume preparation services and training in job-seeking skills;
6. alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance Your ability to work.]

### **[VOCATIONAL REHABILITATION BENEFIT]**

If You are receiving Monthly Payments under the policy, and You are participating in a Vocational Rehabilitation Plan, You may be eligible for an additional Vocational Rehabilitation Benefit. We will pay an additional benefit of [5%-15%] of Your Gross Monthly Payment to a maximum of [\$500 - \$5,000] per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the [Total Benefit Cap] will apply.

### **WHEN VOCATIONAL REHABILITATION BENEFITS END**

Vocational Rehabilitation Benefits will end on the earliest of the following dates:

1. the date We determine that You are no longer eligible to participate in a Vocational Rehabilitation Plan;
2. the date You are no longer participating in a Vocational Rehabilitation Plan; or
3. any other date on which Monthly Payments would stop in accordance with the policy.]

### **[WORKPLACE MODIFICATION BENEFIT]**

If You are disabled and are receiving a payment from Us, an additional Workplace Modification Benefit may be payable to Your Employer for Your benefit. We may reimburse Your Employer for up to 100% of the reasonable costs Your Employer incurs through modifications to the workplace to accommodate Your return to work, and to assist You in remaining at work.

The amount We may pay will not exceed the lesser of:

1. [two - three] times Your last Monthly Payment; or
2. [\$2,000 - \$10,000].

To qualify for this reimbursement, You must:

1. be disabled according to the terms of the policy; and
2. have the reasonable expectation of returning to Active Employment and remaining in Active Employment with the assistance of the proposed workplace modification.

Your Employer must give Us a written proposal of the proposed workplace modification. This proposal must include:

1. input from the Employer, You and Your Doctor;
2. the purpose of the proposed workplace modification;
3. the expected completion date of the workplace modification; and
4. the cost of the workplace modification.

We will reimburse the costs of the workplace modification when We:

1. approve the proposal in writing;
2. receive proof from Your Employer that the workplace modification is complete; and
3. receive proof of the costs incurred by Your Employer for the workplace modification.

This benefit is available on a one time basis.]

### **[[CHILD] [FAMILY MEMBER] CARE EXPENSE BENEFIT**

If You are receiving Monthly Payments under the policy, and You are participating in a Vocational Rehabilitation Plan, You will be eligible for an additional [Child] [Family Member] Care Expense Benefit if You are incurring expenses to provide care for a [Child under age [13-15] [Family Member] who requires personal care assistance.

We will pay a [Child] [Family Member] Care Expense Benefit of [\$250 - \$1,000] per [Child] [Family Member] not to exceed a maximum of [\$1,000 - \$5,000] per month.

The [Child] [Family Member] Care Expense Benefit will end on the earliest of the following dates:

1. the date You are no longer incurring [Child] [Family Member] care expenses;
2. the date You are no longer participating in a Vocational Rehabilitation Plan; [or]

3. [after [12-36] months of [Child] [Family Member] Care Expense Benefits have been paid for each [Child] [or Family Member]; or]
4. any other date on which Monthly Payments would stop in accordance with the policy.

To receive this benefit, You must provide satisfactory proof that You are incurring a [Child] [Family Member] care expense.

[Child][Family Member] care means care or supervision of Your [Child ] or [Family Member;] and care is given by a licensed child-care center or a licensed caregiver who is not related to You by blood or marriage.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the [Total Benefit Cap] will apply.]]

## **INFECTIOUS AND CONTAGIOUS DISEASE BENEFIT INFORMATION**

This Infectious and Contagious Disease Benefit is subject to all other provisions of the policy other than as stated in this section.

For purposes of determining Your coverage and eligibility for Infectious and Contagious Disease Benefits:

1. the terms disability and disabled as used in the policy shall mean Impairment and Impaired as used in this section, and
2. receiving an Infectious and Contagious Disease Benefit shall be treated as receiving a Monthly Payment for disability under this Long Term Disability policy.

### **ELIGIBILITY FOR THE INFECTIOUS AND CONTAGIOUS DISEASE BENEFIT**

You are eligible for benefits if:

1. You either initially test positive for an Infectious and Contagious Disease on or after Your effective date of coverage under this policy; or
2. You initially test positive for an Infectious and Contagious Disease on or after the effective date of Your coverage under a prior policy and are not Impaired on the effective date of Your coverage under this policy. The meaning of prior policy is as defined in the Continuity of Coverage provision.

### **WHEN INFECTIOUS AND CONTAGIOUS DISEASE BENEFITS ARE PAYABLE**

You will begin to receive payments when We approve Your claim, provided You have completed the elimination period and You are Impaired as a result of an Infectious and Contagious Disease.

In order to satisfy the elimination period under this provision, You must have a 20% or more loss in Your Monthly Earnings due to Your Impairment during the elimination period.

### **AMOUNT OF INFECTIOUS AND CONTAGIOUS DISEASE BENEFIT PAYMENT**

We will determine Your Infectious and Contagious Disease Benefit payment amount as shown in the AMOUNT OF PAYMENT in the Certificate of Coverage.

The Infectious and Contagious Disease Benefit will be paid in lieu of the regular Monthly Payment under the policy, not in addition to it.

### **DURATION OF INFECTIOUS AND CONTAGIOUS DISEASE BENEFIT PAYMENTS**

[The Infectious and Contagious Disease Benefit Maximum Period of Payment is [12- 60 months]. [The Infectious and Contagious Disease Benefit Maximum Period of Payment is the Maximum Period of Payment reflected in the SCHEDULE OF BENEFITS.] We will send You a payment each month up to the Maximum Period of Payment. [This is the lifetime cumulative Maximum Period of Payment for any combination of Infectious and Contagious Diseases even if they:

1. are not continuous; and/or
2. are not related.]

The Infectious and Contagious Disease Benefit will end on the earliest of:

1. the date You no longer test positive for an Infectious and Contagious Disease;
2. the date the disease for which You tested positive is no longer an Infectious and Contagious Disease;
3. the date You are no longer Impaired as defined in this section;
4. the end of the Maximum Period of Payment for the Infectious and Contagious Disease Benefit;
5. the date Your Monthly Benefit for disability would have ended if You had been disabled instead of Impaired;
6. after 12 months of payments if You are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when You have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
7. the date Your monthly Disability Earnings exceed 80% of Your Monthly Earnings; or
8. the date You die.

[If Infectious and Contagious Disease Benefits end, the Monthly Payment for a disability may be paid, if You are disabled under the terms of the policy. If You are entitled to a Monthly Payment for disability immediately following the date Your Infectious and Contagious Disease Benefits end, You will not have to satisfy a new elimination period to receive a Monthly Payment for disability. Your receipt of an Infectious and Contagious Disease Benefit will count as Your having received a Monthly Payment for disability and will be subtracted from the Maximum Period of Payment for disability, if applicable.]

### **EXCLUSIONS AND LIMITATIONS**

All of the exclusions under the DISABILITIES NOT COVERED UNDER THE POLICY apply to this Infectious and Contagious Disease Benefit except that loss of professional license, occupational license or certification can be a contributing cause of Your Impairment.

This Infectious and Contagious Disease Benefit provision is subject to the PRE-EXISTING CONDITION LIMITATION provision.

The Continuity of Coverage provision of the policy will apply to this Infectious and Contagious Disease Benefit so long as You were insured for a similar benefit under Your prior policy.]

## **MEDICAL OR COBRA PREMIUM DISABILITY BENEFIT INFORMATION**

If You are disabled and receiving a Monthly Payment for disability under the policy, You may be eligible to receive an additional Medical or COBRA Premium Disability Benefit.

This Medical or COBRA Premium Disability Benefit is subject to all other provisions of the policy other than as stated in this section.

### **WHEN MEDICAL OR COBRA PREMIUM DISABILITY BENEFITS ARE PAYABLE**

Medical or COBRA Premium Disability Benefits are payable for You if You meet all of the following requirements:

1. You are insured under the policy;
2. You are disabled according to the terms of the policy;
3. You are receiving or are eligible to receive a Monthly Payment for disability under the policy; and
4. You are paying premiums for Medical Coverage or COBRA Medical Coverage under Your Employer's plan.

Benefits for a Payable Claim begin the day after You satisfy all of the requirements above.

### **AMOUNT OF MEDICAL OR COBRA PREMIUM DISABILITY BENEFIT PAYMENT**

We will pay You an additional disability benefit per month, equal to the lesser of:

1. the amount of the monthly premium You are paying for yourself only, for Medical Coverage or COBRA Medical Coverage, or
2. [\$300] [\$400] [\$500].

Your Medical or COBRA Premium Disability Benefit will not be reduced by any Deductible Sources of Income listed in the policy.

If You are eligible to receive a Medical or COBRA Premium Disability Benefit for less than 1 month, We will send You 1/30<sup>th</sup> of Your payment for each day You are disabled.

### **DURATION OF MEDICAL OR COBRA PREMIUM DISABILITY BENEFIT PAYMENTS**

We will send You a Medical or COBRA Premium Disability payment until the earliest of the following:

1. the date You are no longer receiving or are no longer eligible to receive a Monthly Payment for disability under the policy;
2. the date You are no longer disabled under the terms of the policy;
3. the date You have received [18 -24]months of Medical or COBRA Premium Disability payments, for a combination of Medical Coverage and COBRA Medical Coverage;
4. the last day You are covered for Medical Coverage, or COBRA Medical Coverage;
5. the last day of the period for which You qualify for COBRA Medical Coverage; or
6. the date You failed to give Us the required proof that You are paying premiums for Medical Coverage or COBRA Medical Coverage.

### **EXCLUSIONS AND LIMITATIONS**

All exclusions and limitations of the policy apply to the Medical or COBRA Premium Disability Benefit.

### **CLAIMS**

The CLAIM INFORMATION section of the policy applies to this Medical or COBRA Premium Disability Benefit. You must also submit proof, in a form acceptable to Us, of Your Medical Coverage or COBRA Medical Coverage premiums that You have paid for yourself.

We may apply the Medical and COBRA Premium Disability benefits due to You to recover any overpayment that may exist on Your claim under the policy.]

## **[LONG TERM DISABILITY BENEFIT INFORMATION]**

### **DEFINITION OF DISABILITY**

You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

You must be under the Appropriate Care of a Doctor in order to be considered disabled.

We may require You to be examined by one or more Doctors, other medical practitioners, or vocational experts of Our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require You to be interviewed by Our authorized representative. Your failure to comply with this request may result in denial or termination of benefits.

### **ELIMINATION PERIOD**

You must be continuously disabled through Your elimination period. Your elimination period is as stated in the SCHEDULE OF BENEFITS and is the period of continuous disability You must satisfy before You are eligible to receive benefits under the policy.

The elimination period begins on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.

### **WHEN YOU RECEIVE PAYMENTS**

You will begin to receive payments when We approve Your claim, providing the elimination period has been met and You are disabled. We will send You a Monthly Payment at the end of each month for any period for which We are liable.

After the elimination period, if You are disabled for less than 1 month, We will send You 1/30<sup>th</sup> of Your Monthly Payment for each day of Your disability.

### **AMOUNT OF PAYMENT**

Your Monthly Payment is the Monthly Benefit stated in the SCHEDULE OF BENEFITS. [After 12 months of payments, Your Monthly Payment will be reduced to 50% of the Monthly Benefit.]

Your Monthly Payment will not be reduced by any other disability benefits You receive.

### **PURSuing SOCIAL SECURITY DISABILITY INSURANCE INCOME (SSDI) BENEFITS**

If:

1. You are disabled according to the terms of this policy;
2. You are not receiving SSDI benefits; and
3. We have a reasonable belief that You are entitled to SSDI benefits,

We will assist You in pursuing Your claim for SSDI benefits, at Our expense. If You pursue a claim for SSDI benefits without Our assistance, You will be responsible for the expense.

You will receive a Monthly Payment under this policy up to the Maximum Period of Payment if:

1. You are eligible for a benefit under this policy;
2. We have a reasonable belief that You are entitled to SSDI benefits; and
3. You are pursuing a claim for SSDI benefits, or You have received a denial of Your claim for SSDI benefits after exhausting all available administrative appeals.

### **RECEIVING SSDI BENEFITS**

If You have submitted a claim to Us or are receiving a Monthly Payment under this policy, You must notify Us promptly if You begin to receive SSDI benefits.

If You are receiving SSDI benefits for the same disability for which You are claiming benefits under this policy, You are not eligible for benefits under this policy.

## **DURATION OF PAYMENTS**

We will send You a payment each month up to the Maximum Period of Payment. Your Maximum Period of Payment is stated in the SCHEDULE OF BENEFITS and will be paid during a continuous period of disability.

## **WHEN PAYMENTS END**

We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer disabled under the terms of the policy;
3. the end of the month following the date You begin to receive SSDI benefits;
4. the date You fail to pursue SSDI benefits with reasonable diligence, if We have determined that You may qualify for such benefits;
5. the date You fail to submit proof of continuing disability;
6. the date You die;
7. after 12 months of payments if You are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when You have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

We will not pay a benefit for any period of disability during which You are incarcerated.

## **DISABILITIES NOT COVERED UNDER THE POLICY**

The policy does not cover any disabilities caused by, contributed to by, or resulting from Your:

1. loss of professional license, occupational license, or certification;
2. participation in a felony;
3. intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;
5. being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor;
6. participation in a war, declared or undeclared, or any act of war;
7. active military duty;
8. active participation in a riot;
9. engaging in any illegal or fraudulent occupation, work, or employment;
10. commission of a crime for which You have been convicted;
11. elective surgery except when required for Your Appropriate Care as a result of Your Injury or Sickness; or
12. traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes.

## **PRE-EXISTING CONDITION LIMITATION**

[Benefits will not be paid if Your disability begins in the first [12-24] months following the effective date of Your coverage and Your disability is caused by, contributed to by, or the result of a condition whether or not that condition is diagnosed at all or is misdiagnosed, for which]:

1. ]You received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the [3-12] months just prior to Your effective date of coverage[.][: or
2. You had symptoms for which an ordinarily prudent person would have consulted a Doctor in the [3-12] months just prior to Your effective date of coverage.]]

[Benefits will not be paid if Your disability begins in the first [12-24] months following the effective date of Your coverage; and Your disability is caused by, contributed to by, or the result of a condition ,whether or not that condition is diagnosed at all or is misdiagnosed, for which:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the [3-12] months just prior to Your effective date of coverage [; or
2. You had symptoms for which an ordinarily prudent person would have consulted a Doctor in the [3-12] months just prior to Your effective date of coverage]; and
3. You were not Treatment Free for [6-12] consecutive months after Your effective date of coverage].

[If there is an increase in the Maximum Benefit after the Policy Effective Date, this PRE-EXISTING CONDITION LIMITATION provision will apply to the amount of the increase in the Maximum Benefit, as of the effective date of the increase.]

## **RECURRENT DISABILITY**

If You have a Recurrent Disability, and after Your prior disability ended, You returned to work for Your Employer for 6 months or less, We will treat Your disability as part of Your prior claim and You do not have to complete another elimination period.

Your Monthly Payment will be based on Your Monthly Earnings as of the date of Your initial claim.

Your disability, as outlined above, will be subject to the same terms of this policy as Your prior claim.

Your disability will be treated as a new claim if Your current disability:

1. is unrelated to Your prior disability; or
2. after Your prior disability ended, You returned to work for Your Employer for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and You will be required to satisfy a new elimination period.

If Our policy terminates and You become eligible for payments under any other group disability plan that replaces Our policy, You will not be eligible for payments under Our policy.]

## **LONG TERM DISABILITY CLAIM INFORMATION**

### **NOTICE OF CLAIM**

We encourage You to notify Us of Your claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be given to Us within 30 days after the date Your disability begins. The notice may be given to Us at Our home office or to Our authorized agent. Failure to give notice within this timeframe shall not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

The claim form is available from [the Policyholder][Your Employer], or You can request a claim form from Us. If You do not receive the form from Us within 15 days of Your request, send Us written proof of claim without waiting for the form.

You must notify Us immediately when You return to work in any capacity.

### **FILING A CLAIM**

You and Your Employer must fill out Your own sections of the claim form and then give it to Your attending Doctor. Your Doctor should fill out his or her section of the form and send it directly to Us.

### **PROOF OF YOUR CLAIM**

You must send Us written proof of Your claim no later than 90 days after Your elimination period. Failure to give such proof within this timeframe shall not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. You must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Your proof of claim, provided at Your expense, must show:

1. that You are under the Appropriate Care of a Doctor;
2. the date Your disability began;
3. the cause of Your disability;
4. the appropriate documentation of Your earnings and Your activities;
5. the extent of Your disability, including restrictions and limitations preventing You from performing Your Regular Occupation;
6. the name and address of any Hospital, Health Facility or Institution where You received treatment, including all attending Doctors; and
7. documentation of prior disability coverage, if applicable.

In some cases, You will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of Your proof of claim, or proof of continuing disability. We will deny Your claim, or stop sending You payments, if the appropriate information is not submitted within 45 days of the request.

You or Your Employer must notify Us immediately when You return to work in any capacity.

### **MAKING PAYMENTS**

Once Your claim has been approved, We will send You a payment at the end of each month for any period for which We are liable.

### **[OVERPAID CLAIMS**

We have the right to recover any overpayments due to:

1. fraud;
2. any administrative error We make in processing a claim; or
3. Your receipt of Deductible Sources of Income.

You must reimburse Us in full. We will determine the method by which the repayment is to be made.

We will not recover more money than the amount We paid You. However, We reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.]

<i>SERFF Tracking Number:</i>	<i>KCLF-126100878</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Kansas City Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42268</i>
<i>Company Tracking Number:</i>	<i>PJ139</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.005 Combined Short Term and Long Term</i>
<i>Product Name:</i>	<i>Group Disability Insurance</i>		
<i>Project Name/Number:</i>	<i>/PJ139</i>		

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: KCLF-126100878 State: Arkansas  
Filing Company: Kansas City Life Insurance Company State Tracking Number: 42268  
Company Tracking Number: PJ139  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: Group Disability Insurance  
Project Name/Number: /PJ139

## Supporting Document Schedules

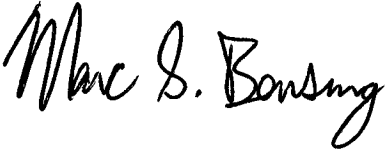
**Review Status:**  
**Satisfied -Name:** Flesch Certification Approved-Closed 05/06/2009  
**Comments:**  
**Attachment:**  
READABILITY CERTIFICATION.pdf

**Review Status:**  
**Satisfied -Name:** Application Approved-Closed 05/06/2009  
**Comments:**  
These forms have been previously approved by your state.  
**Attachments:**  
GA165-AR.pdf  
GA173-AR.pdf

**Review Status:**  
**Satisfied -Name:** statement of variability Approved-Closed 05/06/2009  
**Comments:**  
**Attachments:**  
LTD variable listing.pdf  
STD variable listing.pdf

## READABILITY CERTIFICATION

Form	Score
PJ139	50
CJ139	52
PJ140	50
CJ140	51



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**Name:** Marc S. Bensing

**Title:** Assistant Vice President

**Company:** Kansas City Life Insurance Company

**Date:** April 22, 2009



# Application for Group Term Insurance

## Basic Life, Voluntary Life, Supplemental Life

1. Legal Name of Applicant (Policyholder)		2. Federal Tax ID No.	
3. Nature of Business	Standard Industrial Classification (SIC) Code		
4. Street Address, City, State, Zip			
5. Name of Subsidiaries, Divisions or Affiliates to be Covered			
6. Name and Title of Plan Administrator (Corporate Officer)	Phone No.	Fax	E-mail
7. Name and Title of Correspondent (Routine Accounting Matters)	Phone No.	Fax	E-mail
8. Billing Address(es) - If Different From Street Address			
9. Service of Legal Process Agent (If Different From Plan Administrator)	Phone No.	Fax	E-mail
10. Street Address, City, State, Zip			
11. Proposed Effective Date of Insurance		12. Advance Payment of \$_____ is submitted with this application to be applied by the Company on premiums for insurance when and if issued.	
13. If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, provide: <div style="display: flex; justify-content: space-between;"><div><u>Carrier</u></div><div><u>Type of Coverage</u></div><div><u>Date to be Discontinued</u></div></div>			

### Eligibility

<p>14. Eligible Classes:</p> <table style="width: 100%;"><thead><tr><th style="width: 33%;">Basic Life</th><th style="width: 33%;">Voluntary Life</th><th style="width: 33%;">Supplemental Life</th></tr></thead><tbody><tr><td><input type="checkbox"/> All Full-Time Employees working ____ hrs./week</td><td><input type="checkbox"/> All Full-Time Employees working ____ hrs./week</td><td><input type="checkbox"/> All Full-Time Employees working ____ hrs./week</td></tr><tr><td><input type="checkbox"/> Other_____</td><td><input type="checkbox"/> Other_____</td><td><input type="checkbox"/> Other_____</td></tr></tbody></table> <p>16. Probationary Waiting Period:</p> <table style="width: 100%;"><thead><tr><th style="width: 33%;">Basic Life</th><th style="width: 33%;">Voluntary Life</th><th style="width: 33%;">Supplemental Life</th></tr></thead><tbody><tr><td>____ days/months</td><td>____ days/months</td><td>____ days/months</td></tr></tbody></table> <p>Does this apply to employees hired on or before the effective date? If no, all currently enrolled employees will be covered on the policy effective date regardless of employment date.</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Coverage to be effective the first of the month following completion of probationary waiting period?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>	Basic Life	Voluntary Life	Supplemental Life	<input type="checkbox"/> All Full-Time Employees working ____ hrs./week	<input type="checkbox"/> All Full-Time Employees working ____ hrs./week	<input type="checkbox"/> All Full-Time Employees working ____ hrs./week	<input type="checkbox"/> Other_____	<input type="checkbox"/> Other_____	<input type="checkbox"/> Other_____	Basic Life	Voluntary Life	Supplemental Life	____ days/months	____ days/months	____ days/months	<p>15. Are any individuals currently disabled? <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If yes, provide: <u>Full Name</u></p>  <p><u>Social Security Number</u></p>  <p>17. Number of eligible and enrolled individuals:</p> <table style="width: 100%;"><thead><tr><th style="width: 33%;">Basic Life</th><th style="width: 33%;">Voluntary Life</th><th style="width: 33%;">Supplemental Life</th></tr></thead><tbody><tr><td># eligible ____</td><td># eligible ____</td><td># eligible ____</td></tr><tr><td># enrolled ____</td><td># enrolled ____</td><td># enrolled ____</td></tr></tbody></table>	Basic Life	Voluntary Life	Supplemental Life	# eligible ____	# eligible ____	# eligible ____	# enrolled ____	# enrolled ____	# enrolled ____
Basic Life	Voluntary Life	Supplemental Life																							
<input type="checkbox"/> All Full-Time Employees working ____ hrs./week	<input type="checkbox"/> All Full-Time Employees working ____ hrs./week	<input type="checkbox"/> All Full-Time Employees working ____ hrs./week																							
<input type="checkbox"/> Other_____	<input type="checkbox"/> Other_____	<input type="checkbox"/> Other_____																							
Basic Life	Voluntary Life	Supplemental Life																							
____ days/months	____ days/months	____ days/months																							
Basic Life	Voluntary Life	Supplemental Life																							
# eligible ____	# eligible ____	# eligible ____																							
# enrolled ____	# enrolled ____	# enrolled ____																							

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## Premium

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18. What percentage does the employer contribute towards the premium?

\_\_\_\_ % Basic Life      \_\_\_\_ % Dependent Life      \_\_\_\_ % Voluntary Life      \_\_\_\_ % Supplemental Life

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## Coverage Applied For

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19. ☐ **Basic Term Life Insurance**

☐ Waiver of Premium

☐ Accidental Death & Dismemberment

☐ Dependent Life

Spouse \$ \_\_\_\_\_

Children:

14 days – 6 mos. \$ \_\_\_\_\_

6 mos. – 19 yrs. \$ \_\_\_\_\_

☐ **Voluntary Term Life Insurance**

☐ Waiver of Premium

☐ Accidental Death and Dismemberment

☐ Spouse and Child/ren Life Benefit

☐ **Supplemental Term Life Insurance**

☐ Waiver of Premium

☐ Accidental Death & Dismemberment

☐ Spouse and Child/ren Life Benefit

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## Schedule of Benefits

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20. Please attach a copy of the proposal of benefits sold. Please indicate if benefits applied for are different from those proposed.

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## Agreement and Signatures

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21. It is understood and agreed as follows:

1. No coverage is effective until approved by Kansas City Life Insurance Company at its Home Office in Kansas City, Missouri.
2. Insurance will be effective with regard to those individuals listed above in the Eligibility Section, on the latest of the following dates:  
(a) the effective date approved by the Company; (b) the date this application is signed; or (c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
4. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison..

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, year of \_\_\_\_\_  
City, State

\_\_\_\_\_  
Signature of Writing Agent

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Officer's Signature

\_\_\_\_\_  
Agent's Name and State License ID No. - SSN (Please Print)

\_\_\_\_\_  
Please Print Officer's Name

\_\_\_\_\_  
Signature of Other Agent(s)

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agent(s) Business Address, City, State, Zip

\_\_\_\_\_  
e-mail address

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Agency Code



GRP # \_\_\_\_\_

Kansas City Life Insurance Company

Group Insurance Enrollment Form

**COMPLETED BY EMPLOYER**

1. Employer		2. Location	
3. Full-time employment date	4. Occupation	5. Hours worked/week	6. Annual earnings
7. Coverage class	8. Rehire date	9. This enrollment is: (check all that apply) <input type="checkbox"/> Initial enrollment <input type="checkbox"/> Late entrant <input type="checkbox"/> New hire <input type="checkbox"/> Change <input type="checkbox"/> Other _____	

**COMPLETED BY EMPLOYEE**

10. Last Name, First Name, Middle Initial			
11. Home Address, City, State and Zip			
12. Social Security Number	13. <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Date of Birth (M/D/Y)	15. <input type="checkbox"/> Single <input type="checkbox"/> Married

To apply for coverage(s), complete the following section and sign below. Indicate only those products available through your employer/plan sponsor.

16. Coverage(s) for Employee: <input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Dental If Applicable: <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Voluntary STD If Applicable: Amount: _____ <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Voluntary LTD If Applicable: Amount: _____ <input type="checkbox"/> Vision	17. Coverage(s) for Dependents (Employee coverage required) <input type="checkbox"/> Dependent Life <input type="checkbox"/> Spouse Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Child/ren Voluntary/Supplemental Life Amount: _____ Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren
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[18. If COBRA continuee, please supply qualifying event and date:]

[19. Full Name of Primary Beneficiary and Relationship to you (applicable to life insurance only):]

[20. Full Name of Contingent Beneficiary and Relationship to you (applicable to life insurance only):]

For Dependent Coverage: List each dependent you wish to insure.

21. Name (show last name if different from employee)	Gender	Relationship	Date of Birth	[Other Dental Coverage]	
Spouse		N/A		Y	N
Child				Y	N
Child				Y	N
Child				Y	N
Child				Y	N

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage contained on the reverse side of this Enrollment Form.

22. Signature of Employee: \_\_\_\_\_

Date: \_\_\_\_\_

(To decline any coverages, complete "Declination of Coverage" on page 2.)

**PLEASE DO NOT FILL IN SHADED AREA BELOW - HOME OFFICE USE ONLY**

Group No. _____	Effective Date (M/D/Y)	Class	Coverage Amount
Loc/Div _____			
Cert. # _____			
____ Approved as requested	Basic Life& AD&D		
____ Approved with changes	Basic Dep. Life		
Employee _____	Vol/Supp Life EE		
Spouse _____	Vol/Supp Life SP		
Child/ren _____	Vol/Supp Life Child		
By: _____	STD		
Date: _____	LTD		
	Dental		
	Vision		

**\*PROVISIONS OF COVERAGE**

- I hereby apply to Kansas City Life Insurance Company for Group Insurance as presented to me and authorize my employer to make any necessary deduction from my wages to pay the premium when my insurance becomes effective.

- I represent I am not presently disabled and I am performing the material and substantial duties of my occupation for at least the number of hours as shown in column 5.

- Any person who knowingly presents a false for fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of crime and may be subject to fines and confinement in prison.

- I understand any material misstatement on this enrollment form may result in a denial of a claim and/or discontinuance of coverage.

- I have made a copy of this application for my records.

**DECLINATION OF COVERAGE**

**To refuse coverage(s) for which you are required to pay a portion of the premium, please complete the following section:**

Last Name, First Name, Middle Initial

Employer

Indicate Coverage(s) Declined Below:

Coverage(s) for Employee:

☐ Basic Life & AD&D]

☐ Voluntary/Supplemental Life]

☐ Dental]

☐ Voluntary STD]

☐ Short-Term Disability]

☐ Voluntary LTD]

☐ Long-Term Disability]

☐ Vision]

Coverage(s) for Dependents (Employee coverage required):

[Life: ☐ Spouse ☐ Child/ren]

[Dental: ☐ Spouse ☐ Child/ren]

[Vision: ☐ Spouse ☐ Child/ren]

Reason for refusing coverage: \_\_\_\_\_

I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the coverage indicated. I fully understand by this refusal, I and/or my dependents will not be entitled to any benefits under these coverages marked. If I and/or my Spouse or Child(ren) desire to participate at a later date, coverage(s) may be limited and proof of insurability may be required at my own expense.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If requested to do so by Kansas City Life Insurance Company, please complete the following items.**

Name of Employee:

Age

Gender

Height

Weight

Weight change in last year (gain/loss)

Name of Spouse of Employee (if applicable):

Age

Gender

Height

Weight

Weight change in last year (gain/loss)

During the past five years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition (including high blood pressure)\*; cancer or tumor; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; arthritis or any other disease of the joints, including neck and back disorders; any mental, emotional or nervous disorder; any disorder of the brain, nervous, digestive or reproductive system; muscle or connective tissue disorder; alcohol or drug abuse; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

Employee: ☐ Yes ☐ No

Spouse (life coverage only): ☐ Yes ☐ No

During the past five years, have you been declined coverage for any life or disability insurance?

Employee: ☐ Yes ☐ No

Spouse (life coverage only): ☐ Yes ☐ No

For female, disability applicants only: Are you currently pregnant? ☐ Yes ☐ No

Please supply full details to "Yes" answers. List date(s) of onset, last occurrence, types of treatment including medication. \*For high blood pressure, give date and last reading. If you require additional space, please attach separate sheet.

I(we) authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person or group acting on the part of Kansas City Life Insurance Company: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. "Information" means facts of: a medical nature regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Kansas City Life Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

**I hereby represent that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.**

Signature of Employee: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Spouse: \_\_\_\_\_

Date: \_\_\_\_\_

# KANSAS CITY LIFE INSURANCE COMPANY LONG TERM DISABILITY EXPLANATION OF VARIABLES

## GENERAL POLICY AND CERTIFICATE VARIABLES

Policy Form No. PJ140 and Certificate Form No. CJ140

Bracketed text may be included or omitted according to a policyholder's plan of insurance.

When bracketed text is deleted, paragraphs may be moved to suit the needs of a particular policyholder.

Titles of specific Acts or Laws may be modified as appropriate.

Letters and numbers as they appear in a list, punctuation or words such as "and" or "or" will be included or omitted as needed in order to make the statement or list read correctly.

## SPECIFIC VARIABLES

### POLICY

**FACE PAGE:** All "John Doe" and case specific information will vary as requested for each specific case, and as agreed to by the policyholder and Us.

**TABLE OF CONTENTS:** May be expanded to provide more detail.

### **POLICYHOLDER PROVISIONS:**

Within the **ELIGIBLE CLASS(ES)** provision, the bracketed language [All Employees] can be varied to describe eligible classes under the employer's plan, subject to state law.

The **MINIMUM HOURS REQUIREMENT** will vary according a policyholder's plan, but will not be more restrictive than what is required under state law.

## CERTIFICATE OF COVERAGE

**FACE PAGE:** All "John Doe" and case specific information will vary as requested for each specific case, and as agreed upon between the policyholder and Us.

**Bold Notice:** The language "covers" will appear if the policyholder elects 24-hour coverage. The language "does not cover" will appear if the policyholder elects non-occupational coverage.

**TABLE OF CONTENTS:** May be expanded to provide more detail.

### **SCHEDULE OF BENEFITS:**

Within the **ELIGIBLE CLASS(ES)** provision, the bracketed language [All Employees] can be varied to describe eligible classes under the employer's plan, subject to state law.

The **MINIMUM HOURS REQUIREMENT** will vary according a policyholder's plan, but will not be more restrictive than what is required under state law.

For Base Buy Up plans, the provision entitled **WHO PAYS FOR THE COVERAGE** may be changed to read:

[Basic Benefit:]

Your Employer pays the cost of Your coverage.

[Additional Benefit:]

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**LONG TERM DISABILITY EXPLANATION OF VARIABLES**

[You pay the cost of Your coverage.]

[You and Your Employer share the cost of Your coverage.]

(The references to "Basic Benefit" and "Additional Benefit" may be changed to some other label describing the two different benefit selections, such as "Option 1" and "Option 2".)

The text within the **MONTHLY BENEFIT** provision may be replaced to support various types of benefit plan designs, as follows:

(Incremental Benefit)

**MONTHLY BENEFIT:**

At least [[\$300 - \$1,000] per month, elected in [\$10 - \$500] increments, not to exceed [40% - 100%] of Your Monthly Earnings] up to a Maximum Benefit of [\$500 - \$30,000].

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

(Flat Benefit options)

**MONTHLY BENEFIT:**

[\$500-\$30,000] per month.

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

**MONTHLY BENEFIT:**

The lesser of [\$500 - \$30,000] per month or [10% - 100%] of Your Monthly Earnings.

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

(Base Buy Up plans)

(The references to "Basic Benefit" and "Additional Benefit" may be changed to some other label describing the two different benefit selections, such as "Option 1" and "Option 2".)

**MONTHLY BENEFIT:**

[Basic Benefit:]

[40% - 70%] of Your Monthly Earnings not to exceed [\$ 500 - \$30,000] per month.

[Additional Benefit:]

[10% - 40%] of Your Monthly Earnings not to exceed [\$500 - \$30,000] per month.

In no event will the combined [Basic Benefit] and [Additional Benefit] exceed [40% -80%] of Your Monthly Earnings or the Maximum Benefit amount for the plan.

[Your Monthly Benefit will be specified in Your Enrollment Form as approved by Us.]

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

# KANSAS CITY LIFE INSURANCE COMPANY

## LONG TERM DISABILITY EXPLANATION OF VARIABLES

### MONTHLY BENEFIT:

Monthly Earnings		Monthly Benefit	Monthly Earnings		Monthly Benefit
From	To		From	To	
	[\$749	\$383	\$3,750	\$3,999	\$1,432
\$750	\$999	\$574	\$4,000	\$4,249	\$1,500
\$1,000	\$1,249	\$684	\$4,250	\$4,499	\$1,568
\$1,250	\$1,499	\$752	\$4,500	\$4,749	\$1,636
\$1,500	\$1,749	\$820	\$4,750	\$4,999	\$1,704
\$1,750	\$1,999	\$888	\$5,000	\$5,499	\$1,772
\$2,000	\$2,249	\$956	\$5,500	\$5,999	\$1,843
\$2,250	\$2,499	\$1,024	\$6,000	\$6,499	\$1,906
\$2,500	\$2,749	\$1,092	\$6,500	\$6,999	\$1,970
\$2,750	\$2,999	\$1,160	\$7,000	\$7,499	\$2,034
\$3,000	\$3,249	\$1,228	\$7,500	\$7,999	\$2,098
\$3,250	\$3,499	\$1,296	\$8,000	\$8,499	\$2,161
\$3,500	\$3,749	\$1,364	\$8,500	and above	\$2,225]

[After 12 months of payments, the Monthly Payment will be reduced to 50% of the Monthly Benefit.]

The definition of **MONTHLY EARNINGS** is variable to support the appropriate earnings definition for an individual employer. The following are sample definitions, however they are not all inclusive:

#### (Current Income Excluding Deferred Compensation)

["Monthly Earnings" means Your gross monthly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, renewal commissions, tips and tokens, shift differential, expense reimbursements, bonuses, overtime pay, any other extra compensation, or include income received from sources other than Your Employer].

#### (Current Income and Commissions Excluding Deferred Compensation)

["Monthly Earnings" means Your gross monthly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions just prior to Your date of disability but does not include renewal commissions, renewal commissions, tips and tokens, shift differential, expense reimbursements, bonuses, overtime pay or any other extra compensation, or income received from sources other than Your Employer.

Commissions will be averaged for the lesser of:

- the [12, 24, 36] full calendar month period of Your employment with Your Employer just prior to the date Your disability begins; or
- the period of actual employment with Your Employer.]

#### (Current Income and Bonuses Excluding Deferred Compensation)

["Monthly Earnings" means Your gross monthly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from bonuses for the calendar year just prior to Your date of disability but does not include commissions, renewal commissions, tips and tokens, shift differential, expense reimbursements, overtime pay or any other extra compensation or income received from sources other than Your Employer.

## KANSAS CITY LIFE INSURANCE COMPANY LONG TERM DISABILITY EXPLANATION OF VARIABLES

Bonuses will be averaged for the lesser of:

- a) the [12, 24, 36] full calendar month period of Your employment with Your Employer just prior to the date Your disability begins; or
- b) the period of actual employment with Your Employer.]

(Current Income, Bonuses and Commissions Excluding Deferred Compensation)

["Monthly Earnings" means Your gross monthly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from bonuses and commissions for the calendar year just prior to Your date of disability but does not include renewal commissions, tips and tokens, shift differential, expense reimbursements, overtime pay or any other extra compensation or income received from sources other than Your Employer.

Bonuses and commissions will be averaged for the lesser of:

- a) the [12, 24, 36] full calendar month period of Your employment with Your Employer just prior to the date Your disability begins; or
- b) the period of actual employment with Your Employer.]

The text within the **MAXIMUM PERIOD OF PAYMENT** provision may be replaced to support various types of benefit plan designs, as follows:

### **MAXIMUM PERIOD OF PAYMENT:**

The earlier of:

1. [24][36] months; or
2. the end of the month following the date You begin to receive Social Security Disability Insurance Income (SSDI) benefits.

**DEFINITIONS Section:** The bracketed definitions may be included or omitted if not applicable, according to a policyholder's plan of insurance.

The definition of **GAINFUL OCCUPATION** may be changed to:

**GAINFUL OCCUPATION** means an occupation that is or can be expected to provide You with an income of the lesser of Your Gross Monthly Payment or [\$8,333 - \$10,000] per month within [12-24] months of Your return to work.

### **GENERAL PROVISIONS:**

For Base Buy Up plans, the provision entitled **WHEN COVERAGE BEGINS** may be changed to read:

[Basic Benefit]:

Your Employer pays 100% of the cost of Your [Basic Benefit]. You will automatically be covered for the [Basic Benefit] amount shown in the SCHEDULE OF BENEFITS at 12:01 a.m. Standard Time on the date You are eligible for coverage.

[Additional Benefit]:

You pay the cost of any [Additional Benefit]. If You are eligible for and Enroll for an [Additional Benefit], the [Additional Benefit] will be effective at 12:01 Standard Time on the latest of:

1. the date You are eligible for the [Additional Benefit], if You Enroll for the [Additional Benefit] before that date;

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**LONG TERM DISABILITY EXPLANATION OF VARIABLES**

2. the [first day of the month following the] date You Enroll for the [Additional Benefit], if You Enroll on or within [30-60] days after the date You become eligible for the[ Additional Benefit]; or
3. the [first day of the month following ] the date We approve Your Enrollment Form if Evidence of Insurability is required.]

In order for Your coverage to begin, You must be in Active Employment. Your coverage is subject to payment of premium.]

(The references to "Basic Benefit" and "Additional Benefit" may be changed to some other label describing the two different benefit selections, such as "Option 1" and "Option 2")

For Incremental Benefit plans, the provision entitled **WHEN EVIDENCE OF INSURABILITY IS REQUIRED** may be changed to read:

**WHEN EVIDENCE OF INSURABILITY IS REQUIRED**

Evidence of Insurability is required if:

1. You are a late applicant, which means You apply for coverage more than [30-60] days after the date You are eligible for coverage;
2. You voluntarily canceled Your coverage and are reapplying;
3. You apply for a monthly benefit amount greater than the MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY as shown in the SCHEDULE OF BENEFITS, when You first become eligible for coverage under the policy [.] [;] [or]
4. You apply to increase Your monthly benefit by any amount during the policy year [.] [;] [or]
5. You apply to increase Your monthly benefit by more than [\$100] during an [annual] enrollment period.]

An Evidence of Insurability Form can be obtained from Your Employer.

The bracketed text within the third paragraph within the provision entitled **IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS** may be modified as agreed to by the policyholder and Us.

The following text may be added to the GENERAL PROVISIONS section:

**EVIDENCE OF INSURABILITY ON AMOUNT OF MAXIMUM BENEFIT OVER [\$2,000-\$6,000]**

[The following applies to Your Maximum Benefit in excess of [\$2,000-\$6,000]:

You must submit an Evidence of Insurability Form.

You will be covered for Your Maximum Benefit in excess of [\$2,000- \$6,000] on the later of:

1. the date We approve Your Evidence of Insurability Form; or
2. the date Your Maximum Benefit in excess of [\$2,000-\$6,000] is effective.]

**BENEFIT INFORMATION:**

The **AMOUNT OF PAYMENT** provision may include language to support various types of benefit plan designs, as follows:

(Base Buy Up or Incremental Benefit plans - DIRECT)

[We will follow this process to figure Your payment:

Your Monthly Payment will be the monthly benefit amount You elected and for which premium is being paid, not to exceed [40%- 80%] of Your Monthly Earnings or the Maximum Benefit, minus Deductible Sources of Income.]

(Base Buy Up or Incremental Benefit plans- with 70%-100% All Sources)

## **KANSAS CITY LIFE INSURANCE COMPANY LONG TERM DISABILITY EXPLANATION OF VARIABLES**

[We will follow this process to figure Your payment:

[Your Monthly Payment will be the lesser of:

1. the monthly benefit amount You elected and for which premiums are being paid, [ not to exceed [40%-80%] of Your Monthly Earnings] or the Maximum Benefit], or
2. Your Monthly Earnings multiplied by [70%-100%] minus Deductible Sources of Income.]

([70% -100%] All Sources/FLAT BENEFIT)

[We will follow this process to figure Your payment:

[Your Monthly Payment will be the lesser of:

1. the monthly benefit as shown in the SCHEDULE OF BENEFITS and for which premiums are being paid;  
or
2. [70% - 100%] of Your Monthly Earnings minus Deductible Sources of Income.]

Within the **AMOUNT OF PAYMENT** provision, Item B. the following paragraph may be included for Base Buy Up, Flat or Incremental Benefit plans:

Add Your Disability Earnings to Your Gross Monthly Payment. If the answer is less than or equal to 100% of Your Indexed Monthly Earnings, Your Monthly Payment will be Your Gross Monthly Payment.

From the paragraph that begins "If the answer [in item 4 above] is greater than 100%...", the phrase "in item 4 above" will be removed for Base Buy Up, Flat or Incremental Benefit plans.

The **AMOUNT OF PAYMENT** provision item C. can be deleted in its entirety.

The **IF YOUR DISABILITY EARNINGS FLUCTUATE** provision can be deleted in its entirety.

### **CLAIM INFORMATION**

The provision entitled **OVERPAID CLAIMS** may be changed to read:

#### **OVERPAID CLAIMS**

We have the right to recover any overpayments due to:

1. fraud;
2. Your failure to notify Us promptly of Your receipt of SSDI benefits; or
3. any administrative error We make in processing a claim.

You must reimburse Us in full. We will determine the method by which the repayment is to be made.

We will not recover more money than the amount We paid You. However, We reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.

# KANSAS CITY LIFE INSURANCE COMPANY SHORT TERM DISABILITY EXPLANATION OF VARIABLES

## GENERAL POLICY AND CERTIFICATE VARIABLES

Policy Form No. PJ139 and Certificate Form No. CJ139

Bracketed text may be included or omitted according to a policyholder's plan of insurance.

When bracketed text is deleted, paragraphs may be moved to suit the needs of a particular policyholder.

Titles of specific Acts or Laws may be modified as appropriate.

Letters and numbers as they appear in a list, punctuation or words such as "and" or "or" will be included or omitted as needed in order to make the statement or list read correctly.

## SPECIFIC VARIABLES

### POLICY

**FACE PAGE:** All "John Doe" and case specific information will vary as requested for each specific case, and as agreed to by the policyholder and Us.

**TABLE OF CONTENTS:** May be expanded to provide more detail.

**POLICYHOLDER PROVISIONS:** Within the **ELIGIBLE CLASS(ES)** provision, the bracketed language [All Employees] can be varied to describe eligible classes under the employer's plan, subject to state law.

The **MINIMUM HOURS REQUIREMENT** will vary according a policyholder's plan, but will not be more restrictive than what is required under state law.

**INITIAL RATE GUARANTEE AND RATE CHANGES:** Will vary as agreed to by the policyholder and Us, in accordance with the Rate Manual.

The Rate Guarantee Period may range from 12 to 36 months.

**Premium Due Dates:** These dates will vary on a case-by-case basis.

### CERTIFICATE OF COVERAGE

**FACE PAGE:** All "John Doe" and case specific information will vary as requested for each specific case, and as agreed upon between the policyholder and Us.

**Bold Notice:** The language "covers" will appear if the policyholder elects 24-hour coverage. The language "does not cover" will appear if the policyholder elects non-occupational coverage.

**TABLE OF CONTENTS:** May be expanded to provide more detail.

### **SCHEDULE OF BENEFITS:**

Within the **ELIGIBLE CLASS(ES)** provision, the bracketed language [All Employees] can be varied to describe eligible classes under the employer's plan, subject to state law.

The **MINIMUM HOURS REQUIREMENT** will vary according a policyholder's plan, but will not be more restrictive than what is required under state law.

For Base Buy Up plans, the provision entitled **WHO PAYS FOR THE COVERAGE** may be changed to read:

[Basic Benefit:]

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**SHORT TERM DISABILITY EXPLANATION OF VARIABLES**

Your Employer pays the cost of Your coverage.

[Additional Benefit:]

[You pay the cost of Your coverage.]

[You and Your Employer share the cost of Your coverage.]

(The references to "Basic Benefit" and "Additional Benefit" may be changed to some other label describing the two different benefit selections, such as "Option 1" and "Option 2".)

The text within the **WEEKLY BENEFIT** provision may be replaced to support various types of benefit plan designs, as follows:

(Incremental Benefit)

**WEEKLY BENEFIT:**

[At least [[\$70-\$100] per week, elected in [\$10-\$100] increments, not to exceed [40%-100%] of Your Weekly Earnings] up to a Maximum Benefit of [\$70-\$1,000].

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

(Flat Benefit options)

**WEEKLY BENEFIT:**

[\$100- \$5,000] per week.

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

**WEEKLY BENEFIT:**

The lesser of [\$100-\$5,000] per week or [10%-100%] of Your Weekly Earnings.

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

(Base Buy Up plans)

(The references to "Basic Benefit" and "Additional Benefit" may be changed to some other label describing the two different benefit selections, such as "Option 1" and "Option 2".)

**WEEKLY BENEFIT:**

[Basic Benefit:]

[40% -70%] of Your Weekly Earnings not to exceed [\$100-\$5,000] per week.

[Additional Benefit:]

[10% -40%] of Your Weekly Earnings not to exceed [\$100-\$5,000] per week.

In no event will the combined [Basic Benefit] and [Additional Benefit] exceed [40% -80%] of Your Weekly Earnings or the Maximum Benefit amount for the plan.

[Your Weekly Benefit will be specified in Your Enrollment Form as approved by Us.]

## KANSAS CITY LIFE INSURANCE COMPANY SHORT TERM DISABILITY EXPLANATION OF VARIABLES

Your benefit may be reduced by any Deductible Sources of Income [and Disability Earnings]. Some disabilities may not be covered or may have limited coverage under the policy.

The definition of **WEEKLY EARNINGS** is variable to support the appropriate earnings definition for an individual employer. The following are sample definitions; however they are not all inclusive:

(Current Income Excluding Deferred Compensation)

["Weekly Earnings" means Your gross weekly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, renewal commissions, tips and tokens, shift differential, expense reimbursements, bonuses, overtime pay, any other extra compensation, or include income received from sources other than Your Employer].

(Current Income and Commissions Excluding Deferred Compensation)

["Weekly Earnings" means Your gross weekly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions just prior to Your date of disability but does not include renewal commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than Your Employer.

Commissions will be averaged for the lesser of:

- a) the [12, 24, 36] full calendar month period of Your employment with Your Employer just prior to the date Your disability begins; or
- b) the period of actual employment with Your Employer.]

(Current Income and Bonuses Excluding Deferred Compensation)

["Weekly Earnings" means Your gross weekly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from bonuses for the calendar year just prior to Your date of disability but does not include commissions, renewal commissions, tips and tokens, shift differential, expense reimbursements, overtime pay or any other extra compensation or income received from sources other than Your Employer.

Bonuses will be averaged for the lesser of:

- a) the [12, 24, 36] full calendar month period of Your employment with Your Employer just prior to the date Your disability begins; or
- b) the period of actual employment with Your Employer.]

(Current Income, Bonuses and Commissions Excluding Deferred Compensation)

["Weekly Earnings" means Your gross weekly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from bonuses and commissions for the calendar year just prior to Your date of disability. It does not include renewal commissions, tips and tokens, shift differential, expense reimbursements, overtime pay or any other extra compensation or income received from sources other than Your Employer.

Bonuses and Commissions will be averaged for the lesser of:

- a) the [12, 24, 36] full calendar month period of Your employment with Your Employer just prior to the date Your disability begins; or

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b) the period of actual employment with Your Employer.]

**DEFINITIONS:** The bracketed definitions may be included or omitted if not applicable, according to a policyholder's plan of insurance.

**GENERAL PROVISIONS:**

For Base Buy Up plans, the provision entitled **WHEN COVERAGE BEGINS** may be changed to read:

[Basic Benefit]:

Your Employer pays 100% of the cost of Your [Basic Benefit]. You will automatically be covered for the [Basic Benefit] amount shown in the SCHEDULE OF BENEFITS at 12:01 a.m. Standard Time on the date You are eligible for coverage.

[Additional Benefit]:

You pay the cost of any [Additional Benefit]. If You are eligible for and Enroll for an [Additional Benefit], the [Additional Benefit] will be effective at 12:01 Standard Time on the latest of:

1. the date You are eligible for the [Additional Benefit], if You Enroll for the [Additional Benefit] before that date;
2. the [first day of the month following the] date You Enroll for the [Additional Benefit], if You Enroll on or within [30- 60] days after the date You become eligible for the [Additional Benefit]; or
3. the [first day of the month following] the date We approve Your Enrollment Form if Evidence of Insurability is required.

In order for Your coverage to begin, You must be in Active Employment. Your coverage is subject to payment of premium.]

(The references to "Basic Benefit" and "Additional Benefit" may be changed to some other label describing the two different benefit selections, such as "Option 1" and "Option 2")

For Incremental Benefit plans, the provision entitled **WHEN EVIDENCE OF INSURABILITY IS REQUIRED** may be changed to read:

**WHEN EVIDENCE OF INSURABILITY IS REQUIRED**

Evidence of Insurability is required if:

1. You are a late applicant, which means You apply for coverage more than [30-60] days after the date You are eligible for coverage;
2. You voluntarily canceled Your coverage and are reapplying;
3. You apply for a weekly benefit amount greater than the MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY as shown in the SCHEDULE OF BENEFITS, when You first become eligible for coverage under the policy [.] [;][or]
- [4. You apply to increase Your weekly benefit by any amount during the policy year [.] [;] [or]
5. You apply to increase Your weekly benefit by more than [\$100] during an [annual] enrollment period.]

An Evidence of Insurability form can be obtained from Your Employer.]

The bracketed text within the third paragraph within the provision entitled **IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS** may be modified as agreed to by the policyholder and Us.

The following text may be added to the SCHEDULE OF BENEFITS section and to the GENERAL PROVISIONS section:

**EVIDENCE OF INSURABILITY ON AMOUNT OF MAXIMUM BENEFIT OVER [\$200 - \$5,000]**

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[The following applies to Your Maximum Benefit in excess of [\$200 - \$5,000]:

You must submit an Evidence of Insurability Form.

You will be covered for Your Maximum Benefit in excess of [\$200 - \$5,000] on the later of:

1. the date We approve Your Evidence of Insurability Form; or
2. the date Your Maximum Benefit in excess of [\$200 - \$5,000] is effective.]

**BENEFIT INFORMATION:**

The **AMOUNT OF PAYMENT** provision may include language to support various types of benefit plan designs, as follows:

(Base Buy Up or Incremental Benefit plans - DIRECT)

[We will follow this process to figure Your payment:

Your Weekly Payment will be the weekly benefit amount You elected and for which premium is being paid, not to exceed [40%- 80%] of Your Weekly Earnings or the maximum weekly benefit, minus Deductible Sources of Income.]

(Base Buy Up or Incremental Benefit plans- with 70%-100% All Sources)

We will follow this process to figure Your payment:

Your Weekly Payment will be the lesser of:

1. the weekly benefit amount You elected and for which premiums are being paid, [not to exceed [40%- 80%] of Your weekly Earnings] or the maximum weekly benefit], or
2. Your weekly Earnings multiplied by [70%-100%] minus Deductible Sources of Income.

([70% -100%] All Sources/FLAT BENEFIT)

We will follow this process to figure Your payment:

Your Weekly Payment will be the lesser of:

1. the weekly benefit as shown in the SCHEDULE OF BENEFITS and for which premiums are being paid; or
2. [70% - 100%] of Your Weekly Earnings minus Deductible Sources of Income.

The **AMOUNT OF PAYMENT** provision item **C.** can be deleted in its entirety.

The **IF YOUR DISABILITY EARNINGS FLUCTUATE** provision can be deleted in its entirety.